Supreme Court, U.S.
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No. ____

In The

Supreme Court of the United States

October Term, 1998

THE SECRETARY OF THE WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES, ET AL.,

Petitioners,

v.

PATRICK ADDIS, ET AL.,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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53 pp

QUESTION PRESENTED

Whether the prohibition in 42 U.S.C. § 1396a(a)(17) against attributing to a Medicaid applicant the "income and resources" of non-financially responsible persons, *i.e.*, someone other than the applicant's spouse or parents, prohibits a State from considering the economies of scale of immediate family members living together when determining eligibility for Medicaid.

LIST OF PARTIES

Actual parties to the proceedings in the Court of Appeals were:

Gerald Whitburn, individually and in his official capacity as Secretary of the Wisconsin Department of Health and Social Services, J. Jean Rogers, individually and in her official capacity as the Administrator of the Division of Economic Support, Wisconsin Department of Health and Social Services, and their Agents, Employees, Successors in Office, Assistants and All Others Acting in Concert or Cooperation with Them or at Their Direction or Under Their Control. On January 3, 1995, Gerald Whitburn resigned as the Secretary of the Wisconsin Department of Health and Social Services and on July 6, 1995, Joseph E. Leean became the Secretary of the Wisconsin Department of Health and Social Services, on July 1, 1996, the Wisconsin Department of Health and Social Services became the Wisconsin Department of Health and Family Services, and on that same date, J. Jean Rogers and the Division of Economic Support were transferred to the Wisconsin Department of Workforce Development.

Petitioners herein,

Patrick Addis, Ryan Addis and Sara Addis by their next friends Patrick and Michelle Addis, Dominic Benvenuto, by his next friend Marcia Benvenuto, Craig Johnson by his next friend Donna Worrall, Robert Taloff, Trisha and Joseph Taloff by their next friends Robert and Janice Taloff, and Gisselle Castro by her next friend Carmen Carter, individually and on behalf of all others similarly situated,

Respondents herein.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners, the Secretary of the Wisconsin Department of Health and Family Services, and all of his employees, etc., respectfully pray that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Seventh Circuit entered on September 4, 1998.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Seventh Circuit is reported at 153 F.3d 836 (A-3-18). The opinion of the United States District Court for the Eastern District of Wisconsin (A-19-37) is unreported.

JURISDICTION

The judgment of the United States Court of Appeals for the Seventh Circuit was entered on September 4, 1998. Petitioners filed a Petition for Rehearing With Suggestion of Rehearing En Banc which was denied by Order dated October 5, 1998 (A-1-2). The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTUES AND REGULATIONS INVOLVED

Title 42 U.S.C. § 1396a(a)(17) provides in relevant part, that medical assistance programs must:

> include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels... based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such *income and resources* as are ... *available* to the applicant or recipient and... (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the *financial responsibility* of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to

> the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums, payments made to the State under section 1396b(f)(2)(B) of this title, or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law.

The Code of Federal Regulations provides for "Limitation on the financial responsibility of relatives":

> (a) Except for a spouse of an individual or a parent for a child who is under age 21 or blind or disabled, the agency must not--
>
> (1) Consider income and resources of any relative available to an individual; nor
>
> (2) Collect reimbursement from any relative for amounts paid by the agency for services provided to an individual.
>
> (b) The income and resources of spouses and parents must be considered in determining financial eligibility as provided for the categorically needy in Subpart H and the medically needy in Subpart I of this part.

42 C.F.R. § 435.602 (1992).

STATEMENT OF THE CASE

On December 6, 1993, respondents commenced an action under 42 U.S.C. § 1983 for declaratory and injunctive relief, on behalf of all applicants for and recipients of medical assistance in Wisconsin who have been harmed by a denial or decrease in medical assistance benefits based on Wisconsin's "Family Fiscal Unit Policy." The jurisdiction of the district court was invoked

under 28 U.S.C. §§ 1331 and 1343(3) and (4). Petitioners moved to dismiss the complaint in the district court. The motion was granted, and respondents appealed to the Seventh Circuit Court of Appeals. The Seventh Circuit had three issues before it, petitioners have sought certiorari on only one of those issues.

There is no dispute of fact. The only issue is a question of law.

In 1993, the State of Wisconsin adopted a Family Fiscal Unit policy for determining eligibility for medical assistance. 153 F.3d at 839 (A-7). Under that policy Wisconsin determines the eligibility of each applicant for medical assistance by calculating the applicant's own income and assets and adding to that the prorated share of the income and assets of anyone who is "financially responsible" for the applicant. Only the applicant's spouse or parent(s) is "financially responsible," and therefore in the applicant's "family fiscal unit." *Id.* (A-7-8). "That prorated share is calculated by dividing the legally responsible relative's income and assets by the total number of persons for whom the relative is legally responsible, including himself or herself. Spousal and parental income is thus allocated equally amongst the spouse or parent and those for whom she is financially responsible." *Id.* at n.1 (A-8 n.1). Under this calculation there is no improper attributing of income between non-financially responsible individuals, such as siblings. There is no dispute by respondents that this calculation of an applicant's income is proper. *Id.* at 841 (A-11).

The next step Wisconsin takes is to compare the individual applicant's income (including allocated income) to the need standard for a family of the size of family in which the applicant lives, prorated amongst the number of family members in the applicant's family. This calculation of need would include in a family only a parent or parents and their children.

Respondents claim this proration of need, even amongst immediate family members, violates 42 U.S.C. § 1396a(a)(17)(D) because it is the equivalent of holding one sibling "financially responsible" for another. The district court rejected respondents' view, concluding that based on the definition of financial

responsibility in 42 C.F.R. § 435.602(a)(1) (1992), title 42 U.S.C. § 1396a(a)(17)(D) refers only to the "income and resources" available to an individual, not to the use of a federal family needs chart that has economies of scale built into it (A-29). The district court found Wisconsin's needs standard is not wrongfully attributing the financial responsibility of non-financially responsible persons, but is reflecting the common–sense judgment that living expenses are lower when an individual is sharing accommodations (A-32). The Seventh Circuit reversed the district court, holding that the need standard Wisconsin uses to determine benefits is effectively taking into account the financial responsibility of non-financially responsible persons, in violation of 42 U.S.C. § 1396a(a)(17)(D). 153 F.3d at 841-42 (A-12-13). The Seventh Circuit reasoned that "when a state assumes that an applicant's living expenses are less based solely upon the presence of non-legally responsible persons in the household, thereby reducing the applicant's level of need, the state necessarily is assuming that those persons will be contributing to the applicant's living expenses." *Id.* at 842 (A-13) (citation omitted).

REASONS FOR GRANTING THE WRIT

This case is important to all States and individuals participating in the medical assistance program known as "Medicaid" because the court of appeals' decision prohibits States from considering the size of the family a person lives in when determining that person's need for medical assistance under 42 U.S.C. § 1396a(a)(17)(D). This case involves a significant question of federal law that affects the calculation of millions of dollars of federal and state aid under the Medicaid program. The court of appeals' decision overlooks that Congress has established the family as the relevant building block in assessing an individual's eligibility for medical assistance, instead finding that considering the economies of scale of a family living together is the equivalent of unlawful attribution of income. The court of appeals ignored that the federal Health Care Financing Administration had proposed calculations using the family unit methodology Wisconsin adopted.

I. THIS CASE PRESENTS AN IMPORTANT FEDERAL QUESTION.

This case sets up a conflict between the traditional view of considering a family when determining eligibility for medical assistance and the court of appeals' reading of 42 U.S.C. § 1396a(a)(17)(D) to prohibit the consideration of the economies of scale inherent in a person's living with immediate family members.

To comply with the requirements of the Social Security Act, Wisconsin established a "Family Fiscal Unit" policy whereby the income and assets of an adult are divided and attributed ("deemed") to that adult and his/her spouse and children. The propriety of this calculation is not disputed. Each individual's income is then compared to the need level of one member of a family consisting of a parent or parents and their children (*e.g.*, if two parents and three children, each child's income is compared to the need level of one-fifth of a family of five). The Seventh Circuit's determination that including siblings in this determination of the level of need violates the prohibition against deeming of income except between financially responsible persons, *i.e.*, spouse or children, found in 42 U.S.C. § 1396a(a)(17)(D), means a State may never recognize that a person lives in a family larger than one child with two parents and that a State cannot consider the economies of scale of living in a family with more than one child. The court of appeals' holding requires that in determining a child's need for medical assistance the State must apply the fiction that he is an only child even if he is the sixth child of his mother living in that home. This is a very costly change in the administration of Medicaid for Wisconsin and for numerous other states.[1]

In reaching its conclusion, the Seventh Circuit relied on a similar conclusion by a federal district court in California, ultimately adopted by the Ninth Circuit in an unpublished opinion,

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[1]On remand petitioners expect to show that the court of appeals' decision in this case will cost the State of Wisconsin and the federal matching program 17 million dollars annually because of the number of people whose Medicaid eligibility will change.

Sneede v. Kizer, No. C89-1932, 1990 WL 155532 (N.D. Cal. June 8, 1990), *aff'd mem.*, 951 F.2d 360 (9th Cir. 1991), *cert. denied*, 506 U.S. 939 (1992), and noted a West Virginia district court's similar reasoning in *Richardson v. Lewis*, No. 5:92-0731, slip op. (S.D. W. Va. Sept. 23, 1994). The Seventh Circuit also wrote that its conclusion found support in *Van Lare v. Hurley*, 421 U.S. 338 (1975), in which this Court found that a New York statute, creating the "assumption that the nonpaying lodger is contributing to the welfare household, without inquiry into whether he in fact does so" was "invalid," *id.* at 346, although that case did not involve subsection 17(D).

The court of appeals' conclusion that an individual's income can be compared to one-half of a family of two (married couple or parent and child) and one-third of a family of three (two parents and one child), is logically inconsistent with their determination that an individual's income cannot be considered based on a larger family. There is no dispute that allocating the income of a mother to all four of her children, so each family member has an income of one-fifth of the mother's is acceptable. And yet when each child's income is compared to the level of need, the Seventh Circuit held that each child's need is compared to one-half of a family of two, only including the mother in the family group, but not siblings because they are not legally responsible for each other. The logical inconsistency in this is two-fold: First, this interpretation of the Medicaid rules requires the "income and resources" of the mother to be allocated amongst all her children in the income determination step, but when this "income and resources" term is held to include determination of level of need, all her children *cannot* be considered, so the mother's need is not being allocated in the same manner in both prongs of the calculation. Second, if the Seventh Circuit's reasoning were carried to its logical conclusion, each child would be compared to the need level of a family of one, a parent should not be included because a child is not "financially responsible" for his mother, *i.e.*, the child's income cannot be partially attributed to his mother.

In previous cases this Court determined that Congress may consider that parents will use all funds in a manner to benefit the entire family unit, and reduction of per capita costs based on

family size can be considered. *Bowen v. Gilliard*, 483 U.S. 587, 599-600 (1987). Similarly, in *Anderson v. Edwards*, 514 U.S. 143 (1995), this Court discussed taking into account "reality" and held that California "may rationally assume that a caretaker will observe her duties to all the members of the AU [assistance unit] and will take into account the receipt of any outside income by one child when expending funds on behalf of the AU." *Id.* at 153.

The court of appeals' ruling is also in conflict with the regulations proposed by the Health Care Financing Administration and the United Stated Department of Health and Human Services, although those policy recommendations were eventually withdrawn. (A-26-27, citing Affidavit of respondents' counsel, Patricia DeLessio). The proposed proration policy was withdrawn by the Health Care Financing Administration, citing overwhelming negative commentary regarding the mechanics of instituting this program. The district court herein noted:

> Moreover, the proposed HCFA regulations would have made the system enacted by Wisconsin *mandatory* for all states. It is significant that these regulations were withdrawn, not because they failed to comply with the SSA, but in order to provide the states with more flexibility in administering their Medical Assistance programs. Although the Court is cognizant of the fact that these proposed regulations are not the law, their proposal and history certainly suggests that the Wisconsin plan complies with federal law; at least the federal agency in charge of implementing the Medicaid program thought so.

(A-27).

A decision by this Court would give guidance to all States concerning how to administer Medicaid. No further proceedings in the lower courts are needed to clarify the issue presented. There is no extensive factual record and no dispute of any fact. This important question of federal law is ready for resolution by this Court.

CONCLUSION

For the above reasons, the petition for a writ of certiorari should be granted.

Respectfully Submitted,

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December 1998

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In The

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October Term, 1998

THE SECRETARY OF THE WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES, ET AL.,

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ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

APPENDIX TO PETITION FOR A WRIT OF CERTIORARI

APPENDIX

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United States Court of Appeals

FOR THE SEVENTH CIRCUIT
CHICAGO, ILLINOIS 60604

October 5, 1998.

Before

Honorable RICHARD A. POSNER, Chief Judge

Honorable WALTER J. CUMMINGS, Circuit Judge

Honorable ILANA DIAMOND ROVNER, Circuit Judge

No. 96-3748

PATRICK ADDIS, et al.	] Appeal from the United States
	] District Court for the Eastern
Plaintiffs-Appellants,	] District of Wisconsin
	]
v.	]
	] No. 93 C 1363
GERALD WHITBURN,	]
individually and in his official	]
capacity as Secretary of the	]
Wisconsin Department of	]
Health and Social	]
Services, et al.,	]
	] Rudolph T. Randa,
Defendants-Appellees.	] Judge.

ORDER

On consideration of the petition for rehearing with suggestion for rehearing en bane filed by defendants-appellees on September 24, 1998, no judge in active service has requested a

vote thereon, and all of the judges on the original panel have voted to deny the petition. Accordingly,

IT IS HEREBY ORDERED that the petition for rehearing with suggestion for rehearing en bane be, and the same is, hereby DENIED.

IN THE

UNITED STATES COURT OF APPEALS

For the Seventh Circuit

No. 96-3748

PATRICK ADDIS, *et al.*,

Plaintiffs-Appellants,

v.

GERALD WHITBURN, individually and in his official capacity as Secretary of the Wisconsin Department of Health and Social Services, *et al.*,

Defendants-Appellees.

Appeal from the United States District Court
For the Eastern District of Wisconsin,
No. 93 C 1363-**Rudolph T. Randa**, *Judge.*

ARGUED SEPTEMBER 15, 1997-DECIDED SEPTEMBER 4, 1998

Before POSNER, *Chief Judge*, and CUMMINGS and ROVNER, *Circuit Judges*.

ROVNER, *Circuit Judge*. At issue in this complex case is the validity of various aspects of the State of Wisconsin's Medical Assistance plan. Plaintiffs contend that portions of the state program violate the federal Social Security Act and thus should be enjoined, and that one aspect of the program also violates the Americans with Disabilities Act and the Rehabilitation Act. Rather than granting the requested injunction, the district court dismissed plaintiffs' complaint in its entirety, finding that plaintiffs could not succeed in showing that any of the challenged portions of Wisconsin's program violates federal law. Because we believe that two aspects of the state plan are inconsistent with a provision in the Social Security Act, we reverse the district court's judgment in part and affirm in part.

I.

At this stage of the proceedings, we assume the truth of the facts alleged in plaintiffs' complaint and draw all reasonable inferences from those facts in plaintiffs' favor. *Ashafa v. City of Chicago*, 146 F.3d 459, 461 (7th Cir. 1998). Defendants--the Secretary of Wisconsin's Department of Health and Social Services and others working under his direction--do not dispute that plaintiffs' complaint, as well as their opening brief to this court, accurately describe the operation of Wisconsin's Medical Assistance plan. Their response to the complaint is that the plan does not violate federal law. We therefore base the following summary of Wisconsin's Medical Assistance plan on the allegations in plaintiffs' complaint and on the description provided in plaintiffs' opening brief.

The Medical Assistance program, more commonly known as "Medicaid," is a federal program administered by the states. The federal government provides partial reimbursement to participating states for the cost of medical services provided under the program, as well as for the cost of the program's administration. Yet in order to receive those federal funds, a state must operate its medical assistance program in compliance with the Social Security Act ("SSA") and its implementing regulations

(*see* 42 U.S.C. § 1396a(a)), not always an easy task given the maze of statutory provisions and federal regulations involved. *E.g. Schweiker v. Gray Panthers,* 453 U.S. 34, 43 (1981) ("The Social Security Act is among the most intricate ever drafted by Congress. Its Byzantine construction, as Judge Friendly has observed, makes the Act 'almost unintelligible to the uninitiated.'") We provide a brief overview below of the provisions relevant here.

Under the SSA, states are required to provide medical assistance to certain categories of individuals, whereas coverage to others is optional. *See* 42 U.S.C. § 1396a(a)(10)(A)(i). In all, we shall refer to three categories of potential recipients—the "categorically needy," the "medically needy," and those whose need is determined in relation to the poverty level. Individuals included in the following groups are considered "categorically needy" and thus are automatically entitled to medical assistance coverage: (1) those who receive Aid to Families with Dependent Children ("AFDC") benefits and Supplemental Security Income ("SSI") benefits; (2) pregnant women, children under eighteen and their caretakers, and disabled persons with income and assets at or below AFDC limits; (3) those who lose their eligibility for AFDC benefits due to increased earnings or child support income; and (4) infants under the age of one who are born to women who are eligible for medical assistance at the time of the infant's birth. *Id.*

In addition to the "categorically needy" groups, states are permitted at their option to provide coverage to those who are considered "medically needy," a group generally including pregnant women, children, and disabled and elderly persons who otherwise would qualify for AFDC and SSI benefits except that their income and asset levels exceed the levels permitted under those programs. Wisconsin has chosen to provide medical assistance to those in the "medically needy" category, and it has established standards for obtaining that assistance which are based on the size of the recipient's family. The SSA requires that a state's need standards be "equivalent to 133 1/3 percent of the highest amount which would ordinarily be paid to a family of the same size" under the state's AFDC program. 42 U.S.C.

§ 1396b(f)(1)(B)(i). Moreover, if an applicant's income exceeds the state's need standards, he still may qualify for medical assistance after satisfying a deductible calculated on the basis of his excess income. *See* 42 C.F.R. § 435.831(e).

The final group of medical assistance recipients includes pregnant women and children who do not qualify as either categorically or medically needy but whose family income is at or below a designated percentage of the poverty level. *See* 42 U.S.C. § 1396a(a)(10)(A)(IV-VII). States are required, for instance, to provide medical assistance to pregnant women and infants less than one year of age whose family income is at or below 133 percent of the poverty level; to children under the age of six whose family income is at or below 133 percent of the poverty level; and to children born after September 30, 1993 who are between the ages of six and nineteen and whose family income is at or below 100 percent of the poverty level. *Id.* At their option, states may also provide medical assistance to pregnant women and infants less than one year of age whose family income is at or below 185 percent of the poverty level. *Id.* In Wisconsin, the medical assistance program covering this "poverty level" group is referred to as the "Healthy Start" program. See Wis. Stats. §§ 49.46 & 49.47.

In addition to these specific categorical guidelines, the SSA also requires that state medical assistance plans comply with certain more general principles. First, states must develop and utilize standards for determining income and resource eligibility that are no more restrictive than those employed in determining eligibility for the SSI program for SSI-related persons and the AFDC program for AFDC-related persons. 42 U.S.C. § 1396a(a)(10)(C)(i). Second, states are directed in establishing eligibility standards to provide a reasonable evaluation of the income and resources available to the applicant or recipient and to take account only of income and resources that are actually so available. 42 U.S.C. § 1396a(a)(17)(B) & (C). At the same time, states are prohibited from taking into account "the financial responsibility of any individual for any applicant or recipient"

unless the individual is the applicant's spouse or parent. 42 U.S.C. § 1396a(a)(17)(D). Finally, in determining whether pregnant women and children are eligible for participation in a poverty level program such as Wisconsin's "Healthy Start," states are required to determine family income in accordance with the methodology employed under that state's AFDC program, except to the extent that the methodology is inconsistent with 42 U.S.C. § 1396a(a)(17)(D)'s financial responsibility rule. 42 U.S.C. § 1396a(1)(3)(E).

Having elected to participate in the Medicaid program, Wisconsin must attempt to successfully navigate these federal requirements, the most troublesome of which seems to be the financial responsibility rule of 42 U.S.C. § 1396a(a)(17)(D) ("subsection (17)(D)"). Prior to June 1, 1993, Wisconsin determined eligibility for medical assistance by treating all related persons in a single household as one group, except in limited circumstances. The income and assets of that household group were then compared to the state's need standard for a group of that size to determine eligibility for medical assistance. In a series of administrative hearing decisions, however, the Wisconsin Department of Health and Social Services determined that this practice violates subsection (17)(D) when an individual other than the applicant's spouse or parent has his or her own income that is included in the total income of the household group.

In response to those decisions, Wisconsin adopted the Family Fiscal Unit policy ("FFU") for determining eligibility for medical assistance. Under that policy, Wisconsin no longer considers the income and assets of the entire family group in assessing an applicant's eligibility, but sets up individual fiscal test groups that are designed to avoid assigning income to the applicant that was earned by a non-legally responsible person—*i.e.*, by someone other than the applicant's spouse or parent. As the district court explained it, eligibility is now determined "one individual at a time rather than family by family." R. 19, at 5. Thus, under the FFU policy, eligibility is determined first by calculating the applicant's own income and assets and adding to

them a prorated share of the income and assets of the applicant's spouse or parent.[1] Once the applicant's income is so calculated, it is compared to a pro rata share of the state's need standard for the size of the entire family under consideration. In other words, Wisconsin does not compare the income of a family fiscal unit to the need standard for a unit of that size or even to a pro rata share of the standard for a group of the unit's size; it instead compares the applicant's income as calculated under the FFU policy to the need standard for the entire family group, as prorated amongst the group's individual members.

And as we said, even if the applicant's income exceeds the limits of the state's need standards, he still may qualify for medical assistance after satisfying a deductible amount. Under Wisconsin's FFU policy, it is possible that more than one fiscal unit within a related household will have a medical assistance deductible, and in that case, Wisconsin requires that the deductible amounts be combined in order to establish a deductible for the entire family group. Thus, an individual applicant will not qualify for medical assistance until he satisfies not only his own deductible, but also the combined deductible of his entire family group.

Finally, where a child's caretaker who is herself disabled requests medical assistance both for herself and for the child or children in her care, Wisconsin does not permit the caretaker to deduct from her own income that portion of her income that has been allocated to her children under the FFU policy, provided that the caretaker's income does not fall below the medical assistance categorical levels. As a result, the eligibility of the disabled caretaker for medical assistance is determined without considering the support she provides to her minor children.

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[1] That prorated share is calculated by dividing the legally responsible relative's income and assets by the total number of persons for whom the relative is legally responsible, including himself or herself. Spousal and parental income is thus allocated equally amongst the spouse or parent and those for whom she is financially responsible.

II.

Plaintiffs, all of whom allege that they were harmed by the implementation of Wisconsin's FFU policy, raise a variety of challenges to that policy. First, plaintiffs contend that aspects of the policy are inconsistent with the federal Social Security Act. Plaintiffs further argue that Wisconsin's treatment of disabled caretakers violates the Social Security Act, the Americans with Disabilities Act, and the Rehabilitation Act. The district court rejected each of these contentions, concluding that Wisconsin's medical assistance program fully complies with the requirements of federal law. Our review of the district court's decision is plenary. See *Berman v. GC Services Ltd. Partnership,* 146 F.3d 482, 484 (7th Cir. 1998) (dismissal of complaint and interpretation of federal statute both subject to plenary review).[2]

As we indicated above, the Medicaid program is a cooperative venture between the federal government and the individual states choosing to participate in it. *Michael Reese Physicians and Surgeons, S.C. v. Quern,* 606 F.2d 732, 735 (7th Cir. 1979), *adopted on reh'g en banc,* 625 F.2d 764 (7th Cir. 1980), *cert. denied,* 449 U.S. 1079 (1981); *Vance v. Hegstrom,* 793 F.2d 1018, 1019 (9th Cir. 1986). The program was designed to provide the states with a degree of flexibility in designing plans that meet their individual needs. *Michael Reese*, 606 F.2d at 735. As such, states are given considerable latitude in formulating the

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[2] Plaintiffs brought the instant claims under 42 U.S.C. § 1983 to redress violations of federal law they claim exist in the state program. Defendants have not suggested that such a claim may not be maintained under section 1983. We therefore assume for purposes of this litigation that plaintiffs' claims were properly brought under that statute. *Cf. Smith v. Miller*, 665 F.2d 172, 175 (7th Cir. 1981) ("Congress intended that the 'full panoply' of judicial remedies be available to courts considering in 42 U.S.C. § 1983 actions a state's compliance with the Social Security Act."); *see also Reed v. Blinzinger*, 639 F. Supp. 130 (S.D. Ind. 1986), *aff'd & adopted*, 816 F.2d 296 (7th Cir. 1987) (action brought pursuant to section 1983 alleging that aspects of state medical assistance program were inconsistent with the SSA.).

terms of their own medical assistance plans. *See Smith v. Miller*, 665 F.2d 172, 174 (7th Cir. 1981); *see also generally Dandridge v. Williams*, 397 U.S. 471, 487 (1970); *King v. Smith*, 392 U.S. 309, 318-19 (1968). But the discretion afforded the states is not unlimited. Rather, it is qualified by the requirement that a participating state fully comply with the federal statutes and regulations governing the program. *Schweiker v. Gray Panthers*, 453 U.S. 34, 36-37 (1981); *Smith*, 665 F.2d at 175 & 178. As we explained in *Smith v. Miller*, "a state's discretion in administering the Medicaid program does not shelter it from judicial action on those occasions where it has transgressed the strictures of the Social Security Act." 665 F.2d at 178.

Plaintiffs' most significant challenges to Wisconsin's medical assistance plan relate to whether aspects of the plan comply with subsection (17)(D). We therefore begin with the language of that subsection:

> A State plan for medical assistance must—
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> . . .
>
> (17) . . . include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which . . . (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 ....

Id. This subsection, which allows a state to allocate or "deem" the income of a legally responsible spouse or parent to an applicant for

medical assistance,[3] plainly prohibits a state from taking into account the financial responsibility of any other person for the applicant. Thus, this court and others have uniformly held that in determining eligibility for medical assistance, a state may not allocate to the applicant income of non-legally responsible persons in a related household, such as the applicant's siblings or grandparents. *Reed v. Blinzinger*, 816 F.2d 296, 297 (7th Cir. 1987), *aff'g & adopting*, 639 F. Supp. 130 (S.D. Ind. 1986); *see also, e.g., Malloy v. Eichler*, 860 F.2d 1179, 1183-84 (3d Cir. 1988); *Mitchell v. Lipscomb*, 851 F.2d 734, 736 (4th Cir. 1988); *Olson v. Norman*, 830 F.2d 811, 818-20 (8th Cir. 1987); *Vance*, 793 F.2d at 1024; *Childress v. Bowen*, 833 F.2d 231, 233 (10th Cir. 1987); *State of Georgia Dep't of Medical Assistance v. Bowen*, 846 F.2d 708, 711 (11th Cir. 1988). Indeed, as plaintiffs have alleged, it was precisely to avoid such prohibited deeming of income that Wisconsin adopted its FFU policy, which at the income determination stage, considers only the applicant's own income and a pro rata share of the income and assets of his legally responsible spouse or parent. Plaintiffs do not suggest that Wisconsin runs afoul of subsection (17)(D) at that initial stage. Rather, plaintiffs contend that Wisconsin's policy conflicts with the federal statute only at the final stage—when the applicant's income and resources are compared to a pro rata share of the state's need standard for the entire household group. According to plaintiffs, Wisconsin should be comparing the applicant's income and resources to the needs standard for the size of the applicant's family fiscal unit, not the size of the entire related household. The comparison Wisconsin has chosen to make, plaintiffs argue, assumes that the applicant's need is less because of the presence of non-legally responsible persons in the household. Plaintiffs

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[3] The practice of assigning income to an applicant without also inquiring into whether that income actually is available to the applicant is known as the "deeming" of income. *See Herweg v. Ray*, 455 U.S. 265, 267 (1982); *Vance*, 793 F.2d at 1020 n.1. As the Supreme Court has explained, the "deeming" of income "has the effect of reducing both the number of eligible individuals and the amount of assistance paid to those who qualify." *Gray Panthers*, 453 U.S. at 36.

contend that this assumption has the same effect as deeming the income of those nonlegally responsible relatives to the applicant.

A federal district court in California, and ultimately the Ninth Circuit in an unpublished opinion, accepted a similar argument about the operation of a similar state medical assistance plan in *Sneede v. Kizer*, No. C89-1932, 1990 WL 155532, at *5-7 (N.D. Cal. June 8, 1990), *aff'd mem.*, 951 F.2d 360 (9th Cir. 1991), *cert. denied*, 506 U.S. 939 (1992). The district court in that case found that California's system of prorating need standards "implicitly assum[es] that household members not financially responsible for the applicant are contributing to the applicant's living expenses and thus reducing the applicant's level of need—without inquiring into whether such contributions are actually made." *Id.* at *5. Judge Randa rejected the *Sneede* rationale in this case, however, concluding that "[t]he Wisconsin plan does not attribute the financial responsibility of non-legally responsible individuals to Medicaid applicants or recipients" because the term "financial responsibility" in subsection (17)(D) "refers to income, resources, or an obligation to contribute income or resources to the household." R. 19, at 15. In the district court's view, "[t]he assumption that an individual's need is less because he lives in a household with multiple members is not the equivalent of deeming resources; rather, it reflects a common-sense judgment that living expenses are higher for individuals maintaining their own independent households than they are for individuals sharing accommodations." *Id.* at 15-16. Yet like the court in Sneede, we have some difficulty reconciling that view with the statutory language and the realities of the state's proration system. *See Sneede*, 1990 WL 155532, at *5.

The district court's decision effectively means that subsection (17)(D) applies only when a state is calculating the income available to a medical assistance applicant, and not to the state's assessment, based on that income determination, of whether the applicant is in need of medical assistance. But the statute does not appear to us to be so limited. Nothing in the statutory language suggests that subsection (17)(D) is limited to the calculation of an

applicant's income. Instead, the statute provides that the financial responsibility of someone other than a spouse or parent may not be factored into the determination of "eligibility for and the extent of medical assistance" available under the state's plan. 42 U.S.C. § 1396a(a)(17)(D). In our view, that language must be read as encompassing all aspects of the eligibility determination, including the assessment of the applicant's need, for it is the need standard employed by the state that ultimately will determine both the applicant's eligibility for medical assistance as well as the amount of benefits that will be available. And we agree with the court in *Sneede* that when a state assumes that an applicant's living expenses are less based solely upon the presence of non-legally responsible persons in the household, thereby reducing the applicant's level of need, the state necessarily is assuming that those persons will be contributing to the applicant's living expenses. *Sneede*, 1990 WL 155532, at *5-6. We thus cannot agree with the district court that Wisconsin only is taking account of the "economies of scale" inherent in the sharing of accommodations, for like the court in *Sneede*, we find that argument to be "premised on the assumption that contributions from members of the household [who] are not financially responsible for the applicant are nonetheless *actually* benefitting the applicant by reducing the amount of income/resources that applicant needs for non-medical essentials." *Id.* at *6 (emphasis in Sneede). Assuming the existence of that type of financial assistance is, in our view, the taking into account of the "financial responsibility" of that non-responsible individual. It is thus prohibited by subsection (17)(D). *See also Richardson v. Lewis*, No. 5:92-0731, slip op. at 15-16 (S.D. W. Va. Sept. 23, 1994) (finding similar proration policy inconsistent with subsection (17)(D) in that it "assumes that an individual's need is less because that individual resides with non-financially responsible relatives.").

Our conclusion that Wisconsin's proration policy is premised on an assumption prohibited by the financial responsibility rule of subsection (17)(D) finds support in the Supreme Court's decision in *Van Lare v. Hurley*, 421 U.S. 338 (1975). That case involved the State of New York's policy of

reducing pro rata the shelter allowance provided to AFDC recipients if a nonpaying lodger was living in the recipient's household. The Supreme Court found New York's policy inconsistent with a federal regulation requiring that, in the absence of proof of actual contributions, only the income of a legally obligated parent may be considered in determining the child's eligibility for and the amount of financial assistance. *Id.* at 345 (discussing 45 C.F.R. § 233.90(a) (1974)). The Supreme Court concluded that New York was violating that regulation because its policy was "based on the assumption that the nonpaying lodger is contributing to the welfare household, without inquiring into whether he in fact does so." *Id.* at 346. New York's policy thus ran afoul of the federal bar on "assuming that non-legally responsible persons will apply their resources to aid the welfare child." *Id.*[4]

The Fifth Circuit subsequently concluded that the same AFDC regulation was violated by a Texas policy calling for the proration of a recipient's shelter and utility expenses where noneligible persons were living in the recipient's household.

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[4] The decision of the Second Circuit that the Supreme Court reversed in *Van Lare* took a view of New York's policy that was remarkably similar to that of the district court in this case. *See Taylor v. Lavine*, 497 F.2d 1208, 1215-16 (2d Cir. 1974), *rev'd*, 421 U.S. 338 (1975). The majority opinion in *Taylor* concluded that New York's proration policy "does not attribute a non-existent obligation of support to the lodger, nor does it deny the AFDC-recipient children or caretaker their share of the actual housing expenditures." *Id.* at 1215. The majority found instead that "[p]rorating housing expenses among recipients and non-recipients of public aid accounts for the economies of scale that are realized when individuals live in groups; per-individual housing costs decrease as the number of individuals living together increases." *Id; but see id.* at 1222 (Oakes, J., dissenting) ("It is nonsense . . . to say that the cost of housing to the recipient family decreases when there is a non-paying lodger"). The majority concluded that "the New York scheme does not attribute a false duty of support or a false source of income, but rather accounts for the actual cost of housing to an AFDC-related family." *Id.* at 1216. The Second Circuit majority's view, as we explained above, was flatly rejected by the Supreme Court in *Van Lare*.

Houston Welfare Rights Organization v. Vowell, 555 F.2d 1219 (5th Cir. 1977), *rev'd on other grounds*, 441 U.S. 600 (1979). The Texas policy, like Wisconsin's policy here, had the effect "of lowering the recipient's allowable need so as to lower, in turn, his level of benefits." *Id.* at 1222. The Fifth Circuit found that by implementing such a policy, Texas was violating 45 C.F.R. § 233.90(a), the federal regulation discussed in *Van Lare*:

> The presumption that a recipient's shelter and utility expenses are lowered creating less need when a nonrecipient lives in the household implicitly presumes that the nonrecipient's income is available to offset his share of the shelter and utility costs. If not, the recipient's "need," in terms of actual shelter cost, will not decrease. The [State's] claim that it is only reflecting the economies of scale enjoyed by large groups living together again implicitly presumes that the nonrecipient's income will be available to offset shelter and utilities. Without that presumption, the economies-of-scale argument is irrelevant.

Id. at 1224 (citation omitted); *see also Swift v. Toia*, 461 F. Supp. 578, 581-82 (S.D.N.Y. 1978), *aff'd & adopted*, 598 F.2d 312 (2d Cir. 1979), *cert. denied*, 444 U.S. 1025 (1980). The same presumption underlies Wisconsin's proration policy in this case. Thus, both *Van Lare* and *Vowell* support our view that by prorating the applicant's need based upon the need standard for the applicant's entire family group, including individuals with income who are not legally responsible for the applicant, Wisconsin is violating subsection (17)(D) in that it is implicitly considering the

financial responsibility for the applicant of a non-legally responsible person in the household.[5]

From what we have said about the proration policy, it should be clear that Wisconsin's policy of combining the deductibles of individual family members to establish a deductible for the entire family group also is inconsistent with subsection (17)(D). Whenever a non-legally responsible member of the household, such as a sibling, has a medical assistance deductible that Wisconsin would combine with the applicant's deductible, Wisconsin necessarily would be assigning financial responsibility for the applicant to that non-responsible sibling. Absent the income of that sibling, which produced her own deductible and thus the higher family deductible, the applicant would be entitled to medical assistance by satisfying only her individual deductible amount. Aggregating deductibles in this way thus takes account of the income of the non-legally responsible sibling and thereby violates subsection (17)(D).

III.

Plaintiffs direct our attention to one other aspect of Wisconsin's medical assistance plan. They take issue with Wisconsin's policy that a disabled parent or caretaker, in applying

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[5] We are unpersuaded by defendants' suggestion that other provisions of the SSA somehow authorize the violation of subsection (17)(D) we have described. Although other provisions of the Act require states to develop income standards on a family basis for the medically needy and poverty level categories (*see* 42 U.S.C. §§1396b(f)(1)(B)(i) & 1396a(1)(2)(A)(i)), nothing in those provisions suggests that the standards may be applied in a manner inconsistent with 42 U.S.C. § 1396a(a)(17)(D). Neither provision, for example, defines those individuals who are to be included in the family unit, and thus, neither provision requires the system employed by Wisconsin here. Furthermore, defendants offer no authority supporting the principle underlying their argument—that the needs component of the medical assistance equation is exempt from subsection (17)(D)'s financial responsibility rule. As we explained above, we find such a principle to be incompatible with the plain language of subsection (17)(D).

for medical assistance, is not permitted to deduct from his or her own income that portion which has been allocated to dependent children under the FFU policy. Plaintiffs contend that in some cases, the parent or caretaker's eligibility for medical assistance is therefore determined without regard to the support she provides her dependent children. According to plaintiffs, this policy violates the SSA requirements that a state provide a reasonable evaluation of the applicant's income and resources and that it take into account only income and resources that are actually available to the applicant. *See* 442 U.S.C. § 1396a(a)(17)(B) & (C). We agree with the district court, however, that Wisconsin's plan provides a reasonable basis for determining whether a disabled caretaker will be eligible for medical assistance. *See* R. 19, at 19. Wisconsin is authorized by subsection (17)(D) to allocate a portion of the parent's income to the child in assessing the child's eligibility for medical assistance, and we find nothing in the SSA that requires the State at the same time to take account of that or any of the various other demands on the parent's resources in assessing the parent's own eligibility. We therefore agree with the district court that Wisconsin's treatment of disabled caretakers is consistent with subsections (17)(B) & (C).

Nor do we think Wisconsin's policy violates the provisions of the Americans with Disabilities Act (*see* 42 U.S.C. § 12132) or the Rehabilitation Act (*see* 29 U.S.C. § 794) prohibiting the denial of government benefits on the basis of a disability. Plaintiffs contend that disabled caretakers are subject to disparate treatment under Wisconsin's medical assistance plan and that the disparate treatment is based on the fact that the caretakers are disabled. Although plaintiffs' articulation of the basis for that theory is vague at best, we take them to mean that under Wisconsin's FFU policy, a parent's income generally is allocated pro rata to the children to whom support is provided and that such an allocation should not then be ignored where the parent herself is disabled and is also an applicant for medical assistance. But the fact that plaintiffs may think Wisconsin's policy unfair in that regard does not imply disparate treatment that is traceable to the caretaker's disability. Rather, the original allocation of the parent's income

under Wisconsin's FFU policy is made pursuant to the authorization in 42 U.S.C. § 1396a(a)(17), and that allocation occurs whether or not the parent is herself disabled and whether or not she is applying for medical assistance. The fact that the allocation is then ignored in calculating the parent's own income for medical assistance purposes cannot legitimately be attributed to the applicant's disability.

IV.

For the reasons we have discussed, the district court's judgment dismissing plaintiff's complaint is affirmed in part and reversed in part. The case is hereby remanded to the district court for further proceedings not inconsistent with this opinion. Costs in this appeal are assessed against defendants.

AFFIRMED IN PART,
REVERSED IN PART, AND REMANDED.

A true Copy:
Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WISCONSIN

PATRICK ADDIS, et al.,

Plaintiffs,

v. Case No. 93-C-1363

GERALD WHITBURN, et al.,

Defendants.

DECISION AND ORDER

This case involves a challenge to the Wisconsin Medical Assistance Family Fiscal Unit policy ("FFU policy") and the Wisconsin Medical Assistance disabled caretaker policy. Plaintiffs, who seek to represent a class of all Wisconsin Medical Assistance applicants and recipients whose benefits have been or will be reduced by these policies, contend that the Wisconsin policies violate the Social Security Act ("SSA") and its implementing regulations, the Americans with Disabilities Act ("ADA") and the Rehabilitation Act of 1973.

Before the Court are three motions relating to this action: (1) the defendants' motion to dismiss for failure to state a claim upon which relief can be granted; (2) the plaintiffs' motion for a preliminary injunction prohibiting the defendants from implementing these policies; (3) the plaintiffs' motion to certify this suit as a class action. For the following reasons, the Court concludes that it is clear from the complaint that the Wisconsin Medical Assistance plan complies with the federal statutory and regulatory requirements. Accordingly, the complaint fails to state

a claim upon which relief can be granted and is dismissed. In light of this dismissal, the plaintiffs' motions are denied.

FACTS

The following facts, largely taken from the plaintiffs' complaint, are undisputed:

I. The Medicaid Program

The Medical Assistance program, popularly known as Medicaid, was enacted by the Social Security Act Amendments of 1965, P.L. 89-87, in order to assist the states in providing medical care to poor families with dependent children and disabled individuals unable to afford necessary medical services. *See* 42 U.S.C. § 1396 *et. seq.* In contrast to the other purely federal programs included under the rubric of the SSA, Medicaid is a joint federal-state program. The federal government provides substantial funding for the Medical Assistance program; however, the day-to—day administration of the program is left to the states. Although the states have considerable leeway in determining eligibility for Medical Assistance coverage and the scope of the benefits provided, as is the case with most federally funded programs, the Medicaid money comes with strings attached. *See* Harvey L. McCormick, *Medicare and Medicaid Claims and Procedures*, § 832 (2d ed.).

The first and most important set of conditions imposed by the federal government relate to the eligibility standards for Medical Assistance coverage. States are required to provide Medical Assistance coverage to certain individuals eligible for other assistance programs. The SSA provides that these individuals belong to the class of the "categorically needy" and are

thus automatically entitled to Medical Assistance coverage.[1] 42 U.S.C. § 1396a(a)(10)(A)(i). *See also* Wis. Stats. § 49.46(1). The federal government also permits but does not require states to provide Medical Assistance coverage to individuals who are considered "medically needy." 42 U. S.C. § 1396a(a)(10)(C). An individual may be considered medically needy if he has income and resources that exceed the categorically needy limits but does not have sufficient resources to meet his expenses for necessary medical care. *See* McCormick at § 833. Although the states are given the discretion to set eligibility standards for medically needy coverage, the federal government imposes restrictions on the state standards.[2]

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[1] The "categorically needy" include:

1. Recipients of Aid to Families with Dependant Children (AFDC) benefits and Supplemental Security Income (SSI) benefits;
2. Pregnant women, children under 18 and their caretakers, and disabled persons with income and assets at or below AFDC limits;
3. Persons who lose AFDC eligibility because of increased earnings or child support income; and
4. Infants under the age of one who are born to women eligible for Medical Assistance at the time of birth.

42 U.S.C. §1396a(a)(10)(A)(i). *See also* Wis. Stats. § 49.46(1).

[2] In calculating eligibility for medically needy coverage, the SSA requires that a state's medically needy income levels must be "equivalent to 133 1/3 percent of the highest amount which would ordinarily be paid to a family of the same size" under the state's AFDC program. 42 U.S.C. § 1396b(f)(B)(i). The SSA implementing regulations allow a state to use a higher amount for families of one so long as it does not exceed 133 1/3 percent of the AFDC amount for a family of two. 42 C.F.R. § 435.1007(a)(2). In Wisconsin, the medically needy standard is the same as the SSI benefit level; the standard for groups of two or more is set at 133 1/3 percent of the current state AFDC amount. Wis. Stats. § 49.47(4)(a) and (c)(1).

In recent years, Congress has expanded the Medical Assistance program to include pregnant women and children whose family income is at or below a certain percentage of the poverty level.[3] 42 U.S.C. § 1396a(a)(10)(A)(IV-VII). Pursuant to these new Congressional mandates, Wisconsin enacted the "Healthy Start" program which also provides Medical Assistance coverage for qualifying poor children and pregnant women. Wis. Stats. §§ 49.46, 49.47.

In addition to these specific eligibility requirements, the federal government also imposes general guidelines which the states must follow when developing Medical Assistance eligibility standards. First, the SSA requires that the states use standards for determining income and resource eligibility which are no more restrictive than the standards the state employs in determining eligibility for the Supplemental Security Income (SSI) program and no more restrictive than the methodology the state employs in determining eligibility for the

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[3] Specifically, current federal law requires states to provide Medical Assistance to the following additional classes of individuals:

1. Pregnant women and infants under one year of age whose family income level is at or below 133 percent of the poverty level; States may, at their option, provide Medical Assistance coverage to individuals in this group whose family income level is at or below 185 percent of the poverty level.
2. Children under the age of six whose family income is at or below 133 percent of the poverty level; and
3. Children born after September 30, 1993 who are between the ages of 6 and 19 whose family income is at or below 100 percent of the poverty level.

42 U.S.C. § 1396a(a)(10)(A)(IV-VII).

Aid to Families with Dependent Children (AFDC) program. 42 U.S.C. § 1396a(a)(10)(C)(i). Second, the SSA requires that the states take into account only the income and resources actually available to the applicant or recipient. 42 U.S.C. § 1396a(a)(17)(B). Third, the SSA requires that the state system provide a reasonable evaluation of the income and resources available to the applicant or recipient. 42 U.S.C. § 1396a(a)(17)(C). Fourth, the SSA prohibits the states from taking into account the income or resources of any non-legally responsible individual (*i.e.* anyone other than a parent or spouse) for a Medical Assistance applicant or recipient. 42 U.S.C. § 1396a(a)(17)(D). Finally, in determining the eligibility of pregnant women and children in the Healthy Start program discussed above, states must determine family income in accordance with the methodology employed under the state's AFDC program, except to the extent that it is inconsistent with 42 U.S.C. § 1396a(a)(17)(D). 42 U.S.C. § 1396a(1)(3)(E).

I. Operation of Wisconsin's Medical Assistance Program

The State of Wisconsin has elected to participate in the Medicaid program. *See* Wis. Stats. §§ 49.46, 49.47. The State Department of Health and Social Services ("DHSS") is charged with supervising and administering the Medical Assistance program, Wis. Stats. §§ 46.03(8), 46.206. DHSS in turn contracts with various county departments of social services to run the program at the local level. Wis. Stats. §§ 46.215, 46.22, 49.45(2)(a)(3).

Wisconsin recently changed its policy for determining eligibility for Medical Assistance. Under the old Wisconsin policy, the income and assets of an entire family was calculated and compared to income and asset limits for a family of that size. The new policy -- termed the Family Fiscal Unit (FFU) policy -- determines eligibility for Medical Assistance one individual at a time rather than family by family. Wisconsin enacted this new policy in order to avoid "calculating" or

"assessing" the income of non-legally responsible individuals or relatives as income of program applicants or recipients, which is prohibited by 42 U.S.C. § 1396a(a)(17)(D).[4]

In determining eligibility for Medical Assistance in Wisconsin, an applicant's income and assets are compared to certain set standards. The first step is to determine whether an individual is categorically eligible for the program. If an individual's income and assets exceed the categorical limits, he or she is not categorically eligible. In that case, the individual's income and assets are compared to the medically needy income and asset standards. Wis. Admin. Code, HHS 103.04(1) and (2). If an individual's income exceeds the medically needy limits, he may still be eligible for the program; however, he will be required to pay a Medical Assistance deductible based upon the excess income. Wis. Stats. § 49.47(4)(c)(2). Once an individual accumulates medical bills (not covered by other insurance) which equal the deductible amount, he can then be certified for Medical Assistance for a six-month period. Wis. Admin. Code HHS 103.04(3) and 103.08(2).

Specifically, under the Wisconsin FFU policy, eligibility for AFDC-related and Healthy Start Medical Assistance is determined through the following process: (1) total each individual's income and assets; (2) determine for which persons in the home each individual is legally responsible and divide each individual's income and assets by the number of persons for whom he or she is responsible; (3) allocate the portion of the individual's income and assets to persons for whom he or she is legally responsible and add the allocation from the legally responsible relative to the person's income and assets; (4) determine who is in the Family Fiscal Unit; (5) pick the appropriate income and asset standards (based on FFU size) for each individual, divide the income and asset standards by the number of persons in the FFU and compare the individual's total income and assets to the "per

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[4] Attributing the income of a non-legally responsible member of a household to other members of that household is referred to as the "deeming" of income.

person" income and asset standards to determine financial eligibility; and (6) calculate a Medical Assistance deductible, if necessary. *See* Affidavit of Patricia DeLessio, Exh. 1.

In determining the Medical Assistance eligibility of disabled caretakers, the Wisconsin policy provides that the income that is allocated to the caretaker's children is not deducted from the caretaker's available income when determining the disabled caretaker's Medical Assistance eligibility unless his or her income is below the Medical Assistance categorical levels. As a result, a disabled caretaker's eligibility is determined without considering his or her support of his or her minor children. The caretaker's eligibility is then tested against the medically needy Medical Assistance standard for his or her group size.

LAW

I. LEGAL STANDARD

Rule 12(b)(6) of the Federal Rules of Civil Procedure permits a district court to dismiss a claim for "failure to state a claim upon which relief can be granted." In evaluating a motion filed under this rule, the Court must accept as true all well-pleaded factual allegations contained in the complaint and must draw all reasonable inferences in favor of the plaintiff. *Hishon v. King & Spalding*, 467 U.S. 69, 73 (1984); *Janowsky v. United States*, 913 F.2d 393, 395 (7th Cir. 1990); *Gillman v. Burlington Northern R. Co.*, 878 F.2d 1020, 1022 (7th Cir. 1989). The Court must deny a motion to dismiss unless it appears beyond doubt that a plaintiff is unable to prove any set of facts which would entitle him to relief. *See Conley v. Gibson*, 355 U.S. 41, 45-46 (1957).

II. APPLICATION

The defendants' accept the plaintiffs' description of the Wisconsin Medical Assistance FFU and disabled caretaker policies. The basis of their motion to dismiss is that, contrary to the plaintiffs' claims, the policies in question fully comply with the

federal statute and regulations. Because the facts are undisputed, this dispositive motion on the pleadings is properly before the Court.

Prior to addressing the plaintiffs' specific challenges to the Wisconsin plan, it is important to emphasize that the responsibility for the operation and administration of the Medicaid program is assigned to the states. *See Michael Reese Physicians and Surgeons S.C. v. Quern*, 606 F.2d 732, 735 (7th Cir. 1979) ("Medicaid is an experiment in cooperative federalism which literally abounds with options.") (citations omitted). In implementing the program, the states must comply with the requirements of the federal legislation and regulations. *Smith v. Miller*, 665 F.2d 172, 175 (7th Cir. 1981). However, within the broad statutory and regulatory mandates, a federal court should defer to a state in designing a Medicaid program that best fits its needs. *See Michael Reese*, 606 F.2d at 735 ("Medicaid is designed to be flexible enough to meet the varying needs of each state which elects to participate in the program."); *Warr v. Horsley*, 705 F. Supp, 540, 542 (M.D.Ala. 1989) ("States may design their own Medicaid programs and are given broad discretion in structuring those programs to meet their particular needs and best allocate financial resources according to local conditions.") (citing *Beal v. Doe*, 432 U.S. 438, 440-44 (1977)).

It is interesting to note that the Wisconsin policy at issue here is modeled after a policy proposed in 1993 by the Health Care Financing Administration (HCFA) and the United States Department of Health and Human Services (HHS) for determining Medicaid eligibility. The HCFA proposed regulations mandated a "proration policy" to calculate Medicaid eligibility. Under this mandatory proration policy, each individual in a family unit would have his or her income and resource eligibility measured. Countable income and resources from parents and guardians would be prorated equally among their dependents. Non-responsible members of the family unit would not have to prorate their income among the other family members. Agencies could then compare the individual unit's prorated amount to the

prorated standards to ultimately ascertain health care eligibility. At the time, the HCFA thought that this method best reflected the appellate courts' interpretations of Medicaid law and the Social Security Act. 58 Fed. Reg. 11, 4908-4939. The current Wisconsin policy now under fire is virtually identical to these HCFA's proration regulations. (*See* Affidavit of Patricia DeLessio).

On February 19, 1993, in order to allow the Clinton administration time to review the policies in these regulations, the HCFA delayed the effective date of these standards by six months. 58 Fed. Reg. 9120. Subsequently, the HCFA issued two further delays to complete the review of the policies, pushing back the effective date of the policy to October 18, 1994. 58 Fed. Reg. 44457; 59 Fed. Reg. 8138. Finally, on August 22, 1994, the HCFA withdrew their previous recommendations regarding the proration policy. The HCFA cited overwhelming negative commentary regarding the mechanics of administering the proration policy as the reason for withdrawal. Those submitting comments apparently expressed concern that the new procedures were error prone and unnecessarily complex, and that significant costs would result from the required system changes and personnel retraining. Therefore, the HCFA formally withdrew its regulations. In doing so, the agency stated that it was leaving states flexibility to interpret the current provisions within constraints of court orders or agreements with advocate groups. In the absence of these specific regulations, the methodologies employed by the states will remain valid as long as they comply with the Medicaid statute and any applicable court orders. 59 Fed. Reg. 43052-53. Moreover, the proposed HCFA regulations would have made the system enacted by Wisconsin *mandatory* for all states. It is significant that these regulations were withdrawn, not because they failed to comply with the SSA, but in order to provide the states with more flexibility in administering their Medical Assistance programs. Although the Court is cognizant of the fact that these proposed regulations are not the law, their proposal and history certainly suggests that the Wisconsin plan complies with federal law; at least the federal agency in charge of implementing the Medicaid program thought so.

The Wisconsin Medicaid program provides a reasonable system for determining eligibility for Medical Assistance coverage. It was enacted in response to a federal mandate to avoid the deeming of income of non-legally responsible individuals to other individuals within the household. *See* 42 U.S.C. 1396a(a)(17)(D); *Reed v. Blinzinger*, 639 F. Supp 130 (S.D.Ind. 1986). The plan successfully implements that mandate. The Wisconsin plan may not be perfect and it may not be the best or most sensible way to determine eligibility, but Wisconsin is not required to employ a perfect system or even the best system. All that is required is that its program comply with federal law. Plaintiffs claim that it fails to do so, and it is to these specific compliance challenges that the Court now turns.

A. Plaintiffs' Challenges to Income/Resource Proration Methodology in FFU Policy

The plaintiffs first claim that the FFU policy violates the SSA by requiring the use of separate fiscal test groups in all Healthy Start cases. The plaintiffs point to 42 U.S.C. § 1396a(1)(3)(E), which provides that "family income," for purposes of calculating Medical Assistance eligibility, is to be calculated in accordance with the methodology employed under the state AFDC plan, except to the extent that such methodology is inconsistent with the deeming prohibition of 42 U.S.C. § 1396a(a)(17)(D). *See also*, 42 C.F.R. § 435.401. Under the AFDC program. all related siblings and their parents must be included as one group in determining eligibility. 42 U.S.C. § 602(a)(38). Thus, the plaintiffs contend that separate fiscal test groups are permissible only where the deeming of income would otherwise occur.

Plaintiffs' also claim that the Wisconsin policy violates the SSA because the eligibility standards are not comparable to, and in some cases are more restrictive than, the AFDC program standards. *See* 42 U.S.C. § 1396a(a)(10)(C)(i); 42 C.F.R. § 435.401. According to the plaintiffs, the FFU policy and

the use of prorated income standards apply only to individuals who would be eligible for cash benefits in a single assistance unit under the AFDC filing unit rule. They claim that recipients who would be in the same AFDC assistance units as their co-residents were they receiving cash benefits receive a reduced categorical, medically needy or Healthy Start standard; recipients in other households do not. Plaintiffs further argue that the FFU policy, as applied to categorically and medically needy applicants and recipients, violates the SSA in that it applies lower income standards for calculating income than Wisconsin AFDC payment levels.

The Wisconsin FFU proration policy does not violate the SSA because subsection (17)(D) of section 1396a(a) requires states to use a different method for calculating eligibility for Medicaid than is used to calculate eligibility for AFDC. *See* 42 U.S.C. § 1396a(a)(17)(D); 42 C.F.R. § 435.602. Thus, the federal government *requires* states to take into account all income and resources for an entire family in determining AFDC eligibility, and *prohibits* states from taking into account such income and resources from non-legally responsible individuals in determining Medicaid eligibility. *See Reed*, 639 F. Supp. 130. As a result of these inconsistent mandates, it is inevitable that the process for determining AFDC eligibility will not be the same as the process for determining Medical Assistance eligibility.

Under the old system for determining Medicaid eligibility, a family's income and resources were compared to income and asset standards for a family of that size. In order to comply with the legislation and regulations proscribing the deeming of income from one sibling to another, this family-based model was altered. Under the new Wisconsin scheme, *individual income* is calculated in each case; the department prorates the income and resources for all legally responsible relatives, adds this amount to any individual income and resources, and compares the total to the eligibility standards for a fiscal family unit of the same size. In other words, instead of comparing household income and resources to household standards, Wisconsin compares the income

and resources of an individual within a household to individual standards.

Wisconsin's system provides a reasonable approach to accommodating the competing interests of the entire Medical Assistance scheme. It represents a reasonable, good-faith attempt to comply with the income deeming prohibition of the SSA while reflecting the actual need of individuals within families. In enacting this new policy, the State of Wisconsin was responding directly to section (a)(17)(D); it formulated a system which avoids deeming of income. Moreover, as discussed above, the Wisconsin system follows the approach proposed by the HCFA. Thus, the agency in charge of implementing the Medicaid provision of the SSA obviously thought that the Wisconsin approach comports with federal law. In addition, the Wisconsin provisions fall squarely within the exception contained within 42 U.S.C. § 1396a(1)(3)(E); Wisconsin modified its AFDC methodology to comply with clause (D) of subsection (a)(17). Wisconsin may not have chosen the most narrowly-tailored way of achieving this result, but it is not obligated to do so. To the extent that the Wisconsin Medicaid eligibility standards differ from the AFDC standards, it is to comply with other federal mandates. Accordingly, the Court concludes that the Wisconsin FFU comports with the SSA in this respect.

B. Plaintiffs' Arguments that FFU Policy Violates Anti-Deeming Provisions of SSA

Plaintiffs also challenge several aspects of the Wisconsin FFU policy on the ground that they violate the deeming prohibition of the SSA. Subsection (a)(17)(D) of the SSA requires that a state plan not take into account the financial responsibility of any non-legally responsible individual (*i.e.* anyone other than parents and/or spouses) for the applicant or recipient in determining eligibility. 42 U.S.C. § 1396a(a)(17)(D).

The plaintiffs first argue that the Wisconsin FFU violates subsection (17)(D) by using prorated need standards to

determine eligibility for Medical Assistance coverage. Apparently the plaintiffs object to the fact that the Wisconsin income and resource standards, to which individual income and resources are compared, are based upon the size of the entire family. Thus, one-half of the medically needy standard for a family of two, or one-fifth of the medically needy standard for a family of five, is less than the standard for an individual living alone. The Wisconsin policy thus assumes that an individual's need is less because he or she lives in a household with multiple members. The plaintiffs believe that this constitutes the deeming of income, which is prohibited by 42 U.S.C. § 1396a(a)(17)(D).

In support of this challenge, the plaintiffs rely on a case from the Northern District of California, *Sneede v. Kizer*, No. C89-1932 (slip op. of June 8, 1990). The *Sneede* Court concluded that any assumption that a non-legally responsible individual within a household actually benefitted an applicant for Medical Assistance was prohibited by the anti-deeming provision of subsection 17(D). *Id.* at pp. 8-9. Specifically, the *Sneede* Court held:

> [T]he plain meaning of section 1396a(a)(17)(D) is that the state may not, in determining eligibility, assume the financial responsibility of any person for the applicant (except for parents/spouses) -- whether that financial responsibility is in the form of income attributable to the applicant or in the form of contributions to the applicant's basic living expenses.

Id. at p. 8.

Subsection (17) requires that a state plan include reasonable standards for determining eligibility for Medical Assistance; in doing so, subsection (17)(D) prohibits the states from taking into account "the *financial responsibility* of any individual for any applicant or recipient" except for that of parents and spouses. The issue here is whether the assumption that an

individual's need is less because he or she lives in a household with multiple members constitutes taking into account the financial responsibility of the other members of the household. The Court respectfully disagrees with the holding in *Sneede* and concludes that the imputation of need does not constitute taking into account financial responsibility. The Wisconsin plan does not attribute the financial responsibility of non-legally responsible individuals to Medicaid applicants or recipients. The Court concludes that "financial responsibility," as that term is used in subsection (17)(D), refers to income, resources, or an obligation to contribute income or resources to the household. The assumption that an individual's need is less because he lives in a household with multiple members is not the equivalent of deeming resources; rather, it reflects a common-sense judgment that living expenses are higher for individuals maintaining their own independent households than they are for individuals sharing accommodations.

Moreover, this provision of the Wisconsin plan goes to the establishment of income level benchmarks, governed by subsection (1) of the Medicaid statute. The SSA gives the states considerable discretion, within the federally prescribed ranges, to determine the benchmark standards for income and resources for Medical Assistance applicants. *See* 42 U.S.C. § 1396a(1)(2). The Wisconsin system represents a reasonable attempt to reconcile the demands of both subsections. The Wisconsin plan is consistent with federal law in this regard.

The plaintiffs' next argue that the Wisconsin policy violates the SSA because it results in the double counting of a legally responsible relative's income and resources. Subsection (a)(17) of the statute requires that a state plan "include reasonable standards," 42 U.S.C. a(a)(17), "provide for taking into account only such income and resources as are . . . available to the applicant or recipient," 42 U.S.C. a(a)(17)(B), and "provide for a reasonable evaluation of any such income or resources," 42 U.S.C. a(a)(17)(C). According to the plaintiffs, under the FFU policy an individual's income and resources are counted once as a result of the fact that a pro rata share of the relative's income and resources

are deemed to the Medical Assistance applicant or recipient, and are then counted a second time as a result of the fact that the applicant or recipient's income and resources are compared to reduced prorated income and resource standards because of the presence of the legally responsible relative in the home. In other words, because one-half of the income and resources standards for a family of two is less than the standards for an individual living alone, the assumption that these individuals' need is less because they live in multi-member households constitutes double counting of income and resources and is inherently unreasonable.

The plaintiffs' challenge to this aspect of the Wisconsin plan is based upon the theory, rejected above, that the Wisconsin assumption that an individual's need is less because he or she lives in a household with multiple members is the equivalent of deeming income or resources of others to that individual. For the reasons discussed above, the Court does not think that the adjustment of income and resource benchmarks based upon the number of individuals living in a household is the same as taking into account the income and resources of other individuals. Accordingly, this challenge to the Wisconsin policy must fail.

Finally, the plaintiffs' claim that the Wisconsin FFU policy violates subsection (a)(17)(D) because it requires aggregation of the Medical Assistance deductibles of non-legally responsible individuals. Under the policy, if a family has two Healthy Start age children whose separate incomes are over the Healthy Start limits by $200 and $300 respectively, these excess income amounts are added together to arrive at one Healthy Start deductible amount. According to the plaintiffs, the combination of deductibles results in the combination of excess income of siblings in violation of the prohibition on the deeming of income.

This aggregation of deductibles is not prohibited deeming under the SSA. Combining the individual deductibles to reach one family deductible does not constitute taking into account financial responsibility of one sibling for another; rather, it simply

reaggregates (into one family unit) that which has been disaggregated for the purpose of avoiding the deeming of income to non-legally responsible individuals. As discussed above, it is not improper for Wisconsin to take into account the impact of the incurred expenses of one member of a household on other members of the household. Accordingly, the Court concludes that the Wisconsin policy of combining deductibles is reasonable and in compliance with federal law.

C. Plaintiffs' Challenges to the Disabled Caretaker Policy

Finally, the plaintiffs challenge Wisconsin's treatment of disabled caretakers on the grounds that (1) the Wisconsin policy violates the SSA, and (2) the Wisconsin policy violates the Americans with Disabilities Act (ADA) and the Rehabilitation Act. First, the plaintiffs claim that Wisconsin's treatment of disabled caretakers violates the SSA because the eligibility determination methodology used fails to consider a caretaker's support for his or her children. According to the plaintiffs, this violates the SSA requirements that the state plan take into account only income and resources available to the applicant or recipient and provide for a reasonable evaluation of income and resources. *See* 42 U.S.C. § 1396a(a)(17)(B) and (C).

Under the Wisconsin plan, the income of a parent is prorated and attributed to his or children in determining the children's eligibility for Medical Assistance. However, when determining the parent's eligibility for Medical Assistance, the Wisconsin plan considers the entire amount of that parent's income in determining his eligibility. Thus, argue the plaintiffs, the plan considers income not actually available to the parent (the money spent to support the children in the household) and treats parent-caretakers unreasonably and unfairly.

Plaintiffs' challenges are similar to the "double deeming of income and resources" argument asserted above; it rests on the premise that expenditures should be considered to be

the equivalent of income and resources. As discussed in Section II.B *supra*, the Court rejects this argument. The SSA requires the state plan to take into account only such *"income and resources"* as are actually available to the applicant or recipient. 42 U.S.C. § 1396a(a)(17)(B). It does not require that the state plan make an individualized determination of the varying demands on the resources of applicants and recipients. Such a requirement would place unreasonable demands on the state. Finally, the Court does not think that Wisconsin's failure to consider the support provided to dependent children violates subsection (17)(C). That subsection requires a state to provide a reasonable evaluation of the "income and resources" of the applicant or recipient and not the financial demands made upon him. The Wisconsin plan, while not perfect, provides for a reasonable method of calculating the eligibility of disabled caretakers. As such. the Wisconsin policy complies with the SSA.

The plaintiffs also claim that the Wisconsin disabled caretaker policy violates the ADA and the Rehabilitation Act because it treats disabled caretakers differently from non-disabled caretakers in determining eligibility for Medicaid. Both statutes require that individuals not be discriminated against in determining eligibility for government benefits on the basis of their disability. *See* 29 U.S.C. § 794 (Rehabilitation Act) ("no otherwise qualified individual . . . shall, solely by reason of his handicap" be denied government benefits); 42 U.S.C. § 12132 (ADA) ("no qualified individual with a disability shall, by reason of such disability," be denied public benefits).

According to the plaintiffs, the Wisconsin disabled caretaker policy violates these statutory mandates for the same reason they claim the policy violates the SSA: because the disabled caretaker's income is determined without considering his support for his dependent children; in contrast, pro rata shares are deducted from a non-disabled caretaker's income for the support provided to dependent children. However, for the reasons discussed above, the Court concludes that Wisconsin does not treat disabled caretakers differently *because of their disability*; they are

treated differently because federal law requires it. This does not constitute a violation of the ADA or the Rehabilitation Act.

III. CONCLUSION

The federal requirements imposed upon the states as conditions to receiving Medicaid funding are complex and arcane. The sixty-plus page statute (and the hundred-plus page regulation) is confusing and in some cases contradictory.[5] The statute imposes close to impossible demands on the states which are supposed to be given the freedom to operate their Medical Assistance plans as they see fit. *See Michael Reese*, 606 F.2d at 735; *Horsley*, 705 F. Supp. at 542. Wisconsin has made a good-faith effort to implement a plan for determining Medical Assistance eligibility that conforms to the federal requirements. It even proposed a methodology for determining eligibility based upon the HCFA's own proposal. The HCFA's proposal was withdrawn because it failed to provide states with the necessary flexibility to administer their Medicaid programs.

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[5] One commentator described the Medicaid eligibility requirements as follows:

> The eligibility requirements . . . are complex, and frankly, byzantine. Congress initially predicated Medicaid eligibility on eligibility for the [AFDC] and the [SSI] programs. Since Medicaid's inception, Congress has repeatedly changed eligibility requirements to meet specific needs. The result of such eligibility expansions is a highly technical, virtually incomprehensible body of Medicaid eligibility law.

Eleanor D. Kinney, Rule and Policy Making for the Medicaid Program: A Challenge to Federalism, 51 Ohio St.L.J. 855, 864 (1990).

According to the United States Supreme Court, while Congress has the power to fix the terms under which it disburses federal money to the states,

> The legitimacy of Congress' power to legislate under the spending power . . . rests on whether the State voluntarily and knowingly accepts the terms of the "contract." There can, of course, be no knowing acceptance if a State is unaware of the conditions or *is unable to ascertain what is expected of it.*

Suter v. Artist M., 503 U.S. 347, 112 S. Ct. 1360, 1366 (1992) (quoting *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 17 (1981) (emphasis added). Congress and the HCFA have made it extraordinarily difficult for the states to ascertain what is expected of them in structuring their Medicaid plans. Wisconsin has done its best and has complied with these federal requirements. Accordingly, the Court concludes that nothing in the Wisconsin Medical Assistance plan violates the requirements of the federal legislation and regulations.

NOW THEREEORE, BASED ON THE FOREGOING, IT IS HEREBY ORDERED THAT:

1. The defendants' motion to dismiss is granted and the case dismissed; and

2. In light of this dismissal, the plaintiffs' motions for class certification and for a preliminary injunction are denied.

Dated at Milwaukee, Wisconsin, this 25th day of September, 1996.

SO ORDERED,

_____

HON. RUDOLPH T. RANDA
U. S. District Judge

Supreme Court, U.S.
FILED
JAN 27 1999
CLERK

No. 98-1041

In The
Supreme Court of the United States
October Term, 1998

THE SECRETARY OF THE WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES, ET AL.,

Petitioners,

v.

PATRICK ADDIS, ET AL.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether Wisconsin's Family Fiscal Unit (FFU) policy, as applied to Medical Assistance applicants who have their own income or resources and who are not financially responsible for the support of other household members, violates 42 U.S.C. § 1396a(a)(17)(D) by using a reduced standard of need for these applicants.

LIST OF PARTIES

Petitioners' list of parties accurately describes the petitioners here.

The names of the respondents (the appellants in the Court of Appeals) are: Patrick Addis, Ryan Addis and Sara Addis by their next friends Patrick and Michelle Addis; Craig Johnson by his next friend Donna Worrall; Robert Taloff; Trisha Taloff and Joseph Taloff by their next friends Robert and Janice Taloff. The other respondents listed in the petition were not parties to the proceedings in the Court of Appeals.

This action was originally filed as a class action, but the class has not yet been certified.

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RESPONDENTS' BRIEF IN OPPOSITION

Respondents respectfully request that this Court deny the petition for writ of certiorari, seeking review of the judgment of the United States Court of Appeals for the Seventh Circuit. That opinion is reported at 153 F.3d 836.

JURISDICTION

The judgment of the United States Court of Appeals for the Seventh Circuit was entered on September 4, 1998. Petitioners' Petition for Rehearing With Suggestion of Rehearing En Banc was denied on October 5, 1998. Petitioners' Petition for a Writ of Certiorari was docketed in this Court on December 29, 1998. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATEMENT OF THE CASE

This is a complex case involving the validity of various aspects Wisconsin's Medical Assistance (MA) program. On December 6, 1993, respondents (plaintiffs below) filed their complaint seeking declaratory and injunctive relief on behalf of a class. Motions for class certification and for a preliminary injunction were filed with the complaint. On September 25, 1996, the district court dismissed the complaint, and, in light of that dismissal, also denied the motions for class certification and preliminary injunction.

The Seventh Circuit Court of Appeals (POSNER, Chief Judge, and CUMMINGS and ROVNER, Circuit Judges) considered three separate issues, affirming in part and reversing in part the district court judgment. The Seventh Circuit declined, however, to order the district court to grant the motion for a preliminary injunction, and instead remanded the case to the district court for further proceedings not inconsistent with its opinion. 153 F.3d at 844 (App. A-18). No further proceedings in the district court have been held.

A number of issues remain undecided at this time. The class definition originally described two groups of class members. One group consisted of Medical Assistance (MA) applicants and recipients whose eligibility for health care coverage under the MA program was adversely affected by the Family Fiscal Unit (FFU) policy. The other group consisted of disabled adult parents who had applied for health care coverage under the MA program and whose eligibility for coverage was considered without disregarding income allocated for the support of their children. Distinct claims for relief were pleaded by each group of class members.

The district court dismissed all the claims. The Seventh Circuit affirmed the dismissal of the claims raised by the disabled parents, but reversed the dismissal of the claim brought by persons affected by the FFU policy. It is that claim which is the subject of this petition.

Wisconsin implemented the FFU policy in 1993 in order to bring the MA eligibility determination process into compliance with the Social Security Act, 42 U.S.C. § 1396a(a)(17)(D). 153 F.3d at 841 (App. A-11). The FFU policy sets up a methodology for dividing a household whose members are applying for MA into separate "fiscal test groups." 153 F.3d at 839 (App. A-7). Separate fiscal test groups are needed to avoid the problem of considering income and/or resources that belong to household members who are not legally liable for the support of other household members. The petitioners and respondents here agree that the use of separate fiscal test groups is essential in order to comply with 42 U.S.C. § 1396a(a)(17)(D) (Pet. 4 and 6).

In addition to requiring separate fiscal test

groups, the FFU policy also made another change in the MA eligibility process. The FFU policy mandated reduced assistance standards for the fiscal test groups. 153 F.3d at 839 (App. A-8). Instead of comparing the fiscal test group's income to the eligibility standards established by the Wisconsin Legislature, the fiscal test group's income is compared to a reduced standard. The reduced standard is calculated by taking the standard for the entire household group and dividing it by the number of household members. 153 F.3d at 839 (App. A-8). It is this reduced standard that the Seventh Circuit, following the reasoning of a California federal district court adopted by the Ninth Circuit in *Sneede v. Kizer,*728 F.Supp. 607 (N.D.Cal. 1990), *aff'd mem.*, 951 F.2d 360 (9th Cir.1991), *cert. denied,* 506 U.S. 939 (1992), determined was not permitted under 42 U.S.C. § 1396a(a)(17)(D).

The decision of the Seventh Circuit does not rewrite the petitioners' FFU policy or direct petitioners as to how their FFU policy must be rewritten to comply with 42 U.S.C. § 1396a(a)(17)(D). Contrary to petitioners' assertion (Pet. 7), the Seventh Circuit's decision does not require Wisconsin's MA program to use assistance standards based on one-half of the standard for a family of two and one-third of the standard for a family of three. This methodology, or others, may be considered in further proceedings before the district court.

REASONS FOR DENYING THE WRIT

This case concerns the intricacies of the MA program established under Title XIX of the Social Security Act. As the Seventh Circuit observed in its opinion, operating an MA program in compliance with the Social

Security Act and its implementing regulations is "not always an easy task given the maze of statutory provisions and federal regulations involved." 153 F.3d at 838 (App. A-5). The MA program contains overlapping layers of eligibility requirements, and each state's program is unique.

The intricacies of the MA program, however, should not complicate this Court's consideration of the petition. The petition should be denied because there is no conflict among the Courts of Appeals, because the decision of the Seventh Circuit does not conflict with any decisions of this court, because the Seventh Circuit correctly interpreted federal law, and because – at its current stage of development – this case does not present an important issue of federal law.

The particular eligibility question at stake here has been considered by two Courts of Appeals. Both the Seventh Circuit here and Ninth Circuit in *Sneede* reached identical conclusions in interpreting 42 U.S.C. § 1396a(a)(17)(D). This Court declined to review the *Sneede* decision in 1992. No other appellate court has considered this issue.

The Seventh Circuit's well-reasoned, thorough decision carefully considered the competing and intricate demands of the Social Security Act. Contrary to petitioners' argument, the Seventh Circuit's decision that the use of reduced assistance standards is contrary to 42 U.S.C. § 1396a(a)(17)(D) does not conflict with either *Bowen v. Gilliard,* 483 U.S. 587 (1987), or *Anderson v. Edwards,* 514 U.S. 143 (1995). (Pet. 7-8). Those decisions discuss the eligibility process in a different public assistance program, the Aid to Families with Dependent Children (AFDC) program. The eligibility determination processes for AFDC

and MA are very different. *See* cases cited by the Seventh Circuit, 153 F.3d at 841 (App. A-11).

The differences between AFDC and MA were highlighted in the background discussion which accompanied final rules issued by the Health Care Financing Administration (HCFA) of the Department of Health and Human Services on August 22, 1994. 59 Fed. Reg. 43051. The HCFA rules would have mandated a method for states to follow in situations like the situation presented by this case. HCFA explained the differences between AFDC and MA:

> ...an AFDC statutory change in 1984 mandated that all family members living together be considered one family unit for AFDC eligibility purposes and that the income and resources of all family members be pooled. As a result, AFDC sometimes requires attributing income and resources from persons other than spouses or parents (siblings, stepparents, grandparents, legal guardians and alien sponsors) as available to the applicant or recipient. Use of the AFDC methods for cases involving income from persons other than spouses or parents, however, is contrary to section 1902(a)(17)(D) of the Act. [42 U.S.C. § 1396a(a)(17)(D)]

59 Fed. Reg. 43051.

In these final rules, HCFA withdrew its earlier regulations before they became effective and declined to mandate a specific eligibility determination process. Contrary to the assertion of the petitioners here, the decision of the Seventh Circuit does not conflict with the HCFA

regulations (Pet. 8) because those regulations were withdrawn before being implemented.

Nor does this case, at its current stage of development, present an important issue of federal law. Wisconsin's FFU policy is a small part of Wisconsin's MA program. The impact of the Seventh Circuit decision has not been considered by the district court. Questions of class membership, class certification, and methods of implementation remain unanswered.

CONCLUSION

For the reasons given above, respondents respectfully request that the petition be denied.

Respectfully Submitted,

January, 1999

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In the Supreme Court of the United States

GERALD WHITBURN, SECRETARY, WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES, ET AL., PETITIONERS

v.

PATRICK ADDIS, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether Wisconsin's method of determining benefit eligibility and need levels for a class of Medicaid applicants is consistent with the requirement of 42 U.S.C. 1396a(a)(17)(D) that such methods not "take into account the financial responsibility" for the applicant of any other person except a parent or spouse.

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In the Supreme Court of the United States

No. 98-1041

GERALD WHITBURN, SECRETARY, WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES, ET AL., PETITIONERS

v.

PATRICK ADDIS, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is submitted in response to the Court's order inviting the Solicitor General to express the views of the United States.

STATEMENT

1. The Medicaid Act, 42 U.S.C. 1396 *et seq.*, establishes a cooperative program under which the federal government provides matching funds to assist participating States in providing, among other things, medical assistance for families with dependent children "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. 1396. The Act is administered at the federal level by the Secretary of Health and Human Services, who disburses

matching funds to States with approved plans for providing medical assistance. See generally 42 U.S.C. 1301(a)(6), 1302(a), 1396, 1396b (1994 & Supp. III 1997). Although participation in the program is voluntary, and state plans may vary considerably in detail, participating States must comply with a number of requirements imposed by the Act and the Secretary's regulations. See 42 U.S.C. 1396a (1994 & Supp. III 1997); *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990); *Atkins* v. *Rivera*, 477 U.S. 154, 157 (1986).

The Act requires state Medicaid plans to include "reasonable standards * * * for determining eligibility for and the extent of medical assistance under the plan." 42 U.S.C. 1396a(a)(17). Those standards must "provide for taking into account only such income and resources as are * * * available to the applicant or recipient," and must not "take into account the financial responsibility of any individual for any applicant or recipient of assistance * * * unless such applicant or recipient is such individual's spouse or * * * [minor] child." 42 U.S.C. 1396a(a)(17)(B) and (D). The Act thus precludes participating States from assuming, either for purposes of ascertaining threshold eligibility or for purposes of setting benefit levels, that anyone other than a spouse or parent is contributing financially to the support of an applicant for Medicaid benefits. See also 42 C.F.R. 435.602(a)(1).

2. Some people become eligible for Medicaid benefits automatically after they qualify for benefits under another federal or federally supported program, such as Supplemental Security Income. See 42 U.S.C. 1396a(a)(10)(A)(i)(I)-(II). Other forms of eligibility depend on an assessment of the applicant's financial need, measured against standards prescribed by the States under general rules set by the Medicaid Act and

other federal law. See 42 U.S.C. 1396a(a)(10)(A)(i)(III)-(VII) and (a)(10)(A)(ii), 1396d(a); see also Pet. App. A5-A6; 58 Fed. Reg. 4908-4909, 4915 (1993). In performing such assessments for purposes of its Medicaid plan, Wisconsin first determines the income and assets that are deemed to be available to the applicant under plan rules, and then compares those amounts to applicable standards of need. See Pet. App. A7-A8, A23-A24.

In the first step of the process (determining income and assets), the State takes into account only the applicant's own income, plus a share of the income of any financially responsible spouse or parent.[1] The share of a spouse or parent's income to be allocated to the applicant is determined by dividing that income by the total number of people for whom the spouse or parent is financially responsible, including himself or herself. If, for example, the applicant is a child living with both parents and one sibling, any income that the sibling may have (from, for instance, disability benefits or child support payments) will be ignored, in compliance with 42 U.S.C. 1396a(a)(17)(D). The sibling's presence in the household will be taken into account, however, in attributing the parents' income, because each parent is recognized as financially responsible both for the other parent and for both children. Thus, if one parent earns $600 each month and the other $400, one-fourth of each amount will be attributed to each member of the household. If the applicant child has no independent income, his or her income for Medicaid eligibility purposes will be $250. Respondents do not

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[1] Although the Act requires assessment of both income and assets, in the interest of simplicity we focus on the determination of income for purposes of this brief.

challenge this aspect of Wisconsin's procedure. See Br. in Opp. 3.

Having determined the income attributable to a Medicaid applicant, the State next compares that income to an applicable standard of need. In many circumstances, including those relevant here, the Act requires the State, subject to the important exception assertedly applicable in this case, to use need standards (as well as methods of determining income) based on those it used under the former program of Aid to Families with Dependent Children (AFDC). See 42 U.S.C. 1396a(a)(10)(A)(i)-(ii), (C)(i)(III) and (*l*)(3)(E) (1994 & Supp. III 1997), 1396b(f) (1994 & Supp. III 1997), 1396u-1(a) and (b) (Supp. III 1997); 42 C.F.R. 435.601(a) and (b).[2] The Medicaid standards, like those under AFDC, generally treat each family as a unit, and vary according to family size. See generally, *e.g.*, 42 U.S.C. 602(a)(7)-(8), (31) and (38) (1994) (repealed); see also 42 U.S.C. 1396b(f)(1)(B) and (f)(3). Those standards are, moreover, established on the premise that there are economies inherent in group living, so that,

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[2] The AFDC program was replaced in 1996 by a new program, Temporary Assistance for Needy Families. Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Pub. L. No. 104-193, Tit. I, 110 Stat. 2110 (enacting provisions codified at 42 U.S.C. 601 *et seq.* (Supp. III 1997)); see *Saenz* v. *Roe*, No. 98-97 (May 17, 1999), slip op. 4. PRWORA simultaneously amended the Medicaid Act, however, to provide that, subject to qualifications not at issue here, statutory and other references in or under the Medicaid Act, including those involving "income and resource standards and income and resource methodologies," continue to refer to the former AFDC provisions and the various state plans implemented under them, "as in effect as of July 16, 1996, with respect to [each] State." 42 U.S.C. 1396u-1(a) (Supp. III 1997), enacted by PRWORA § 114(a)(2), 110 Stat. 2177.

for example, the need standard for a family of two is less than twice the standard for a family of one, and one-third the standard for a family of three is less than one-half the standard for a family of two. See Pet. App. A31, A33; compare *Bowen* v. *Gilliard*, 483 U.S. 587, 599 (1987).

To make need determinations for individual Medicaid applicants, Wisconsin compares the individual income levels it has calculated for the applicant to an individual need standard that it computes by prorating the need standard for a family the size of the applicant's entire family (limited to those family members who live together in the same household), including family members whose incomes were not counted in determining the income and resources attributable to the applicant. Thus, in the example given above, the State would use the need standard for a family of four, even though no income belonging to the applicant's sibling was included in computing the applicant's income. If the State set its need standard for a family of four at $360, the individual need standard would be $90, and the child in the example would not be eligible for Medicaid assistance, because his or her income was determined to be $250 for Medicaid purposes.[3]

3. Petitioners are the Secretary of the Wisconsin Department of Health and Family Services and other state officials responsible for the administration of Wisconsin's Medicaid program. Respondents sued petitioners in federal district court, purporting to represent

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[3] In some cases, the child would become eligible if an amount equal to the excess of attributed income ($250) over individual need ($90) had been spent on medical care, health insurance, or certain other allowable expenses. See Pet. App. A24; Wis. Stat. Ann. § 49.47(4)(c)(2) (West Supp. 1998).

(among others) a class of actual or potential Medicaid beneficiaries. Respondents sought declaratory and injunctive relief on the ground that Wisconsin's method of computing applicable individual need standards takes into account the financial responsibility for the applicant of family members other than the applicant's spouse or parents, in violation of 42 U.S.C. 1396a(a)(17)(D).[4]

The district court rejected respondents' challenge to the State's method of calculating need. Pet. App. A19-A37. After reviewing the law governing the federal and state programs (*id.* at A19-A25), the court noted that responsibility for the operation of Medicaid programs is committed largely to the States, and that the state methodology at issue is one that the Secretary once proposed to mandate through federal regulations (*id.* at A26-A27). The court then rejected any general challenge to the State's method of calculating income on the basis of proration within units consisting of an applicant and his or her spouse and parents, holding that the State's procedure reflects a reasonable implementation of applicable federal rules. *Id.* at A28-A30. The court also rejected respondents' specific claim that the use of need standards based on the total number of family members living in the household, including members whose income may not be counted as available

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[4] Respondents also challenged the State's rules for determining the satisfaction of Medicaid "deductible[s]," and its rules for determining Medicaid eligibility when a disabled individual applies for benefits both for himself or herself and for a child or children in his or her care. See Pet. App. A8; Br. in Opp. 3. The court of appeals struck down the deductible rules (Pet. App. A16), but sustained the State's treatment of applications by disabled caretakers (*id.* at A16-A18). Neither of those rulings has been challenged in this Court. See Pet. 3.

to the applicant under Section 1396a(a)(17)(D), violates that Section. Observing that the provision in question prohibits taking into account "the *financial responsibility*" for the applicant of any individual other than a parent or spouse (*id.* at A31), the court reasoned that "[t]he assumption that an individual's need is less because he lives in a household with multiple members is not the equivalent" of deeming every member's income to be available to the applicant, but rather merely "reflects a common-sense judgment that living expenses are higher for individuals maintaining their own independent households than they are for individuals sharing accommodations." *Id.* at A32; see *id.* at A32-A33. The court accordingly granted petitioners' motion to dismiss respondents' complaint. *Id.* at A37.

The court of appeals reversed in relevant part. Pet. App. A1-A18. The court agreed with respondents that the State's use of a need standard based on total family size, by "assum[ing] that the applicant's need is less because of the presence of non-legally responsible persons in the household," has "the same effect as deeming the income of those nonlegally responsible relatives to [be available to] the applicant," and on that basis the court held that that approach to assessing need violates Section 1396a(a)(17)(D). *Id.* at A11-A12. Noting that "it is the need standard employed by the state that ultimately will determine both the applicant's eligibility for medical assistance * * * [and] the amount of benefits that will be available," the court observed that "when a state assumes that an applicant's living expenses are less based solely upon the presence of non-legally responsible persons in the household, thereby reducing the applicant's level of need," it "necessarily is assuming that those persons

will be contributing to the applicant's living expenses." *Id.* at A13.

The court rejected the argument that Wisconsin's procedure merely takes account of "economies of scale." Pet. App. A13. It reasoned that any computation of need "premised on the assumption that contributions from members of the household [who] are not financially responsible for the applicant are nonetheless *actually* benefitting the applicant by reducing the amount of income/resources that applicant needs for non-medical essentials" amounts, in effect, to "the taking into account of the 'financial responsibility' of that non-responsible individual." *Ibid.* A13. The court concluded:

> [B]y prorating the applicant's need based upon the need standard for the applicant's entire family group, including individuals * * * who are not legally responsible for the applicant, Wisconsin is violating subsection (17)(D) in that it is implicitly considering the financial responsibility for the applicant of a non-legally responsible person in the household.

Id. at A15-A16. The court of appeals accordingly reversed the district court's dismissal of respondents' complaint, and remanded the case to that court for further proceedings. *Id.* at A18.

DISCUSSION

The court of appeals in this case adopted one plausible interpretation of the relevant provisions of the Medicaid Act. While the alternative construction advanced by petitioner is not unreasonable, it has not been adopted by any court of appeals, and previous federal regulations based on that construction were

withdrawn before they became effective. In the absence of any conflict on the issue among the courts of appeals, or between the courts and the Secretary, the decision below does not warrant review by this Court.

1. As we have explained (see pp. 2-5, *supra*), some individuals or families are eligible for Medicaid benefits only if their income and assets fall below threshold amounts. In many cases the Medicaid Act requires, subject to the important exception at issue in this case, that each State determine Medicaid eligibility using the methods for determining income, and the threshold need standards, that the State used for purposes of the former AFDC program. See p. 4 & note 2, *supra*.

The statutory question presented in this case arises because, beginning in 1984, Congress required that computations of income and need for AFDC purposes be made on a combined basis for defined family groups —including, for example, all eligible siblings living in the same household. See 42 U.S.C. 602(a)(38) (1994) (repealed); *Bowen* v. *Gilliard*, 483 U.S. 587, 592-594 (1987). A number of courts thereafter held, however, that States could not apply the new AFDC grouping requirements in assessing income for purposes of Medicaid eligibility, if doing so would—as in the case of siblings—violate the proscription in 42 U.S.C. 1396a(a)(17)(D) against "tak[ing] into account the financial responsibility of any individual [other than a spouse or parent] for any applicant or recipient of [Medicaid] assistance." See, *e.g.*, *Malloy* v. *Eichler*, 860 F.2d 1179, 1182 (3d Cir. 1988); *Georgia Dep't of Med. Assistance* v. *Bowen*, 846 F.2d 708, 710 (11th Cir. 1988); see also 42 U.S.C. 1396a(*l*)(3)(E) (providing that, for certain groups of Medicaid applicants, family income "shall be determined" using the State's AFDC methodology, "except to the extent such methodology is

inconsistent with clause (D) of subsection (a)(17)"). Those decisions, in which the Secretary ultimately acquiesced, left state Medicaid administrators without definitive guidance concerning what modifications to AFDC income-determination and need-determination methods were required or permitted before those methods were used for determining eligibility for Medicaid. See 59 Fed. Reg. 43,051 (1994) (describing issue); 54 Fed. Reg. 39,427-39,428 (1989) (same); see also 58 Fed. Reg. 4924 (1993) ("States only know that they cannot use AFDC standard filing unit policy, but do not know what to use instead.").

The Secretary initially sought to address that uncertainty in commentary accompanying the publication, in 1989, of proposed regulations specifically addressing a number of other issues under the Act. 54 Fed. Reg. at 39,426-39,428. The commentary identified and discussed the issue, and proposed the adoption of a nationwide policy: No one but a spouse or parent would be automatically grouped with a Medicaid applicant for purposes of determining eligibility, but all family members in a household who applied for Medicaid benefits would be treated as a single group under the AFDC rules. *Ibid.* The commentary specifically noted, however, that there were other possible approaches, and the Secretary invited comments from all interested parties concerning how best to reconcile the Act's requirements that States make eligibility determinations based on AFDC standards, but at the same time attribute financial responsibility only to parents and spouses. *Id.* at 39,428.

The Secretary's invitation drew a mixed response. Some commenters supported the Secretary's proposal, while others argued that treating relatives other than spouses and parents as part of one family unit would

violate Section 1396a(a)(17)(D), even if the family were allowed the option (not available under AFDC) of excluding such relatives from the eligibility computations by not applying for Medicaid benefits on their behalf. See 58 Fed. Reg. at 4916. That argument was also made in litigation. In 1990, a federal district court enjoined the State of California from enforcing eligibility rules that were consistent with the Secretary's initial proposal, and enjoined the Secretary from requiring or permitting the use of such rules by any State within the Ninth Circuit. *Sneede* v. *Kizer*, 728 F. Supp. 607 (N.D. Cal. 1990) (enjoining enforcement of California rules); *Sneede* v. *Kizer*, No. C89-1932-TEH, 1990 WL 155532 (N.D. Cal. May 3, 1990) (certifying circuit-wide class to challenge Secretary's policy); see *Sneede* v. *Coye*, 856 F. Supp. 526, 530 (N.D. Cal. 1994) (noting that initial injunction was later extended to cover federal defendants).

In attempting to frame a remedial decree responsive to the district court's initial decision in *Sneede*, the Secretary joined California officials in proposing a revised system for determining Medicaid eligibility in that case. See *Sneede* v. *Kizer*, No. C89-1932-TEH, 1990 WL 155532 (N.D. Cal. June 8, 1990) (addressing dispute over how to comply with initial decision), aff'd mem., 951 F.2d 360 and 362 (9th Cir. 1990), cert. denied, 506 U.S. 939 (1992). Under that proposal, Medicaid applicants' income would have been computed on the basis of family groups that included only children, parents, and spouses whose financial responsibility for each other could properly be taken into account under Section 1396a(a)(17)(D). The resources so determined would then have been compared, however, to individual need standards derived by ascertaining the size of the family group that would have been used for AFDC purposes

(which would typically be larger than the special Medicaid family group), and then dividing the AFDC need standard for a family of that size by the total number of members in the AFDC group. See *Sneede*, 1990 WL 155532, at *4. The method for determining eligibility proposed by the Secretary in *Sneede* was thus essentially the same as the Wisconsin method at issue in this case.

The district court in *Sneede* rejected the use of that method, holding that Section 1396a(a)(17)(D) prohibits taking the presence of a non-financially-responsible member of a Medicaid applicant's household into account in determining the applicable need standard, just as it prohibits taking such a member's income into account in determining the financial resources available to the applicant. *Sneede*, 1990 WL 155532, at *5-*7. The Ninth Circuit affirmed that decision in an unpublished (and hence non-precedential, see 9th Cir. R. 36.3) opinion. *Sneede* v. *Kizer*, No. 90-15141, 1991 WL 268830 (9th Cir. Dec. 13, 1991) (decision noted at 951 F.2d 362 (Table)), cert. denied, 506 U.S. 939 (1992).

After further analysis, and in light of those developments, the Secretary ultimately abandoned the particular nationwide policy that had been proposed in the 1989 regulatory commentary. Instead, in early 1993, the Secretary adopted, subject to public comment and a deferred effective date, final regulations that would have required States outside the Ninth Circuit (where the *Sneede* injunction remained in effect) to adopt and apply essentially the same methodology that had been proposed (and rejected by the courts) in *Sneede*. See 58 Fed. Reg. at 4908, 4915-4917, 4923-4924, 4930-4931 (§§ 435.602(d), 435.604 and 435.606). The commentary accompanying publication of the new regulations recognized that the approach adopted "[might] not be

ideal," but it characterized that approach as the drafters' "best attempt to harmonize the competing demands of the various provisions of the Medicaid statute[,] as interpreted by most of the courts[,] * * * in a manner consistent with simplicity of administration." 58 Fed. Reg. at 4916.

The 1993 regulations addressing this issue were given a delayed effective date to allow an opportunity for public comment, and that date was later extended twice in order to allow for further review. See 58 Fed. Reg. at 4916, 4924; 59 Fed. Reg. at 43,051. Describing the comments she received on this issue, the Secretary explained that, with one exception, the 13 States and seven interest groups that submitted comments all objected to the methodology the regulations would require for determining eligibility, characterizing it as "error prone," "unnecessarily complex," and likely to result in "significant administrative costs." 59 Fed. Reg. at 43,051. A technical advisory group consulted by the Secretary also expressed a preference for a policy that would "minimize[] the disruption of current approaches"; and advocates for benefit recipients "endorse[d] allowing States a choice of several options, but strongly oppose[d] allowing the budgeting method in the * * * regulation to be one of [those] options." *Ibid.*

In light of those comments, the Secretary ultimately decided not to include in her regulations any one federal policy on how to adapt the rules and methods then applicable under AFDC for purposes of determining Medicaid eligibility. She instead withdrew the 1993 regulations on the issue, which had never become effective, in favor of "allowing States flexibility, within any constraints imposed by court orders or agreements with recipient advocate groups, to interpret the current

provisions" of federal law. 59 Fed. Reg. at 43,052. As the Secretary explained, "in the absence of specific regulatory guidance on the methodologies for establishing income and resource eligibility" for affected Medicaid applicants, the States would merely be "required to use methodologies that comply with the statute and any applicable court orders." *Ibid.*

2. The textual question ultimately at issue in this case is a narrow and rather subtle one: Whether using a need standard that takes account of certain economies of scale that are generally involved in group living amounts to "tak[ing] into account the financial responsibility" of one household member for another, within the meaning of Section 1396a(a)(17)(D). The court of appeals adopted one permissible answer to that question, holding that the use of such a standard does violate Section 1396a(a)(17)(D).

Section 1396a(a)(17) governs the determination of both "eligibility for and the extent of medical assistance" under the Act. The reference to the "extent" of assistance may be read to suggest that the prohibition in clause (D) should apply not only to determining the income attributable to an applicant, but also to determinations that involve comparing that income to a need standard, especially where that comparison establishes an amount of medical or similar expenses the applicant must incur before becoming eligible for Medicaid. See note 3, *supra*. In addition, it is possible to read "financial responsibility" more broadly than did the district court in this case (see *id.* at A31-A32), to encompass "the assumption that contributions from members of the household [who] are not financially responsible for the applicant are nonetheless *actually* benefitting the applicant by reducing the amount of income/resources that [the] applicant needs [or that others, such as the

applicant's parents, must expend on the applicant's behalf] for non-medical essentials." *Id.* at A13 (quoting *Sneede*, 1990 WL 155532, at *6). There may also be a question whether it is appropriate, as a policy matter, to import into a medical assistance program, without any modification, family-size-based need standards that were designed to reflect the sort of "economies of scale" that commonly apply to expenses such as housing, utilities, and to some extent food.[5] Finally, the decision below is consistent with the line of appellate cases holding that Section 1396a(a)(17)(D) requires modification of the family units used to determine an applicant's *income* under AFDC, and with the decision of the only other court of appeals to have addressed, albeit in a non-precedential opinion, the precise question presented by this case. See *Malloy*, and cases there cited; *Sneede*, 1991 WL 268830.

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[5] In the context of a general economic assistance program it makes sense to take account of the fact that a family of three may not pay any more for housing or electricity, and not much more for food, than a family of two. It is not, however, obvious that it will generally cost a mother less to buy medical care for a second child, simply because she already has to buy care for the first. Patients do not typically realize significant "economies of scale" on expenses for medical essentials such as doctor visits, vaccinations, or eyeglasses. At the same time, the ascertainment of need under the Medicaid program also takes account of family expenses other than those for medical care, and for those expenses economies of scale presumably are present. Thus, although it is true that the decision below treats income and need determinations differently in limited respects (see Pet. 7), it is also true that in the Medicaid context there are at least some grounds on which it may be sensible to do so. It is realistic to assume that a parent's resources will be stretched evenly over herself, her spouse, and all of her dependents. It is not necessarily realistic to expect that all her financial needs, or those of her children, can be as easily prorated.

That the decision below rests on a permissible interpretation of Section 1396a(a)(17)(D) does not require the contrary conclusion concerning the different interpretation of that provision advanced by petitioner. As the district court explained in this case, it is also possible to read the statutory phrase "financial *responsibility*" to refer to an obligation to contribute available income or assets to the common good, without reference to the distinct question of an applicant's financial *need*. Pet. App. A31-A32 (emphasis altered). Moreover, as petitioner points out (Pet. 7), the court of appeals' construction of Section 1396a(a)(17)(D) may result in seeming inconsistencies between the required determinations of income and need.[6] Indeed, as we have described, the Secretary previously advocated adoption of an eligibility-determination method similar to Wisconsin's, both in the *Sneede* litigation and in the 1993 regulations. See also 54 Fed. Reg. at 39,427-39,428; *Sneede*, 1991 WL 268830, at **2-**3 (describing arguments advanced by the State and the Secretary in that case).

The existence of reasonable textual and policy arguments on both sides of the issue has consistently led the Secretary to acknowledge that the question presented in this case is a difficult one, to which there may be a

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[6] All agree, for example, that if a single mother lives with her three children, one-fourth of the mother's income is properly attributed to each child, even if the Medicaid application unit in question excludes one of the children (perhaps because he has independent income, which may not properly be attributed to his siblings). Although the "excluded" child is therefore taken into account in ascertaining the income deemed available to the application unit, under the decision below the existence of the same child must be ignored when it comes to ascertaining the unit's financial need.

number of plausible answers. See 54 Fed. Reg. at 39,428 (noting existence of alternatives and soliciting comments); 58 Fed. Reg. at 4916 (recognizing difficulty of problem and characterizing new regulation as a "best attempt"); see also Pet. App. A30-A33 (district court's opinion sustaining State's position in this case); cf. *Sneede*, 1991 WL 268830, at **4 (declining to award attorneys' fees because position advanced by State and Secretary in that case "had a reasonable basis in law and fact"). Such situations are not uncommon in the administration of complex national benefit programs, and are often resolved through the adoption, by federal administrators, of a formal interpretation of the relevant law. In this case, the Secretary could reasonably have issued regulations adopting either petitioners' or respondents' construction of the Medicaid Act, and that determination would have been not only permissible, but authoritative. See, *e.g.*, *Your Home Visiting Nurse Servs., Inc.* v. *Shalala*, 119 S. Ct. 930, 933-934 (1999); *Atkins* v. *Rivera*, 477 U.S. 154, 162 (1986); *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844 (1984); *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 43-44 (1981).[7]

In this unusual instance, however, the Secretary, after thorough consideration, decided not to promulgate regulations adopting any definitive interpretation of

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[7] The Ninth Circuit was accordingly wrong to suggest, in its memorandum opinion in *Sneede*, that the terms of the Medicaid Act compelled the result it reached, regardless of the Secretary's construction of the Act. See 1991 WL 268830, at **2-**3; compare *Gray Panthers*, 453 U.S. at 43 ("The Social Security Act is among the most intricate ever drafted by Congress," and Congress has therefore "conferred on the Secretary exceptionally broad authority to prescribe standards for applying certain sections of the Act," including 42 U.S.C. 1396a(a)(17)(B).).

the relevant statutory provisions or to impose any one methodology on the States. She determined that it would instead be preferable, under all the circumstances, to allow States participating in the Medicaid program the greatest possible flexibility to apply those provisions, in light of their own state plans, administrative structures, resource constraints, and policy priorities. See 59 Fed. Reg. at 43,052. In her announcement of that determination, however, the Secretary made clear that the resulting freedom to adopt different methods for determining Medicaid eligibility would remain subject to each State's ultimate responsibility to "comply with the statute and [with] any applicable court orders." *Ibid.* Respondents brought the present case on the theory that Wisconsin's method of determining Medicaid eligibility does *not* "comply with the statute."

Federal courts have a general obligation to adjudicate federal claims properly before them; and, in the absence of any authoritative interpretation by the Secretary, it was proper for both courts that considered this case to identify and construe for themselves the relevant provisions of federal law. As we have explained, the construction urged by respondents and adopted by the court of appeals is a permissible one. The court's decision does not conflict with any decision of this Court or of any other court of appeals, or with any construction presently adopted by the Secretary.[8]

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[8] In addition, the likely practical impact of the decision is obscured by Wisconsin's impending implementation (in July 1999) of a "child health plan" approved under the State Children's Health Insurance Program, 42 U.S.C. 1397aa *et seq.* (Supp. III 1997), which makes additional federal funds available to participating States to help fund health care for low-income children who do not qualify for Medicaid benefits. See generally 42 U.S.C. 1397aa(a)

Under these circumstances, the question presented by the State's petition for a writ of certiorari does not warrant review by this Court.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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(purpose), 1397bb(3)(A)-(B) (eligibility screening and coordination with Medicaid), 1397dd(d) (coordination with Medicaid), 1397jj(b) (defining "targeted low-income child" as one with family income below specified Medicaid eligibility levels, and not otherwise eligible for Medicaid) (Supp. III 1997).

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No. 98-1041

In The

Supreme Court of the United States

THE SECRETARY OF THE WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES, ET AL.,

Petitioners,

v.

PATRICK ADDIS, ET AL.,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

SUPPLEMENTAL BRIEF IN RESPONSE TO BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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By order dated March 1, 1999, this Court invited the Solicitor General to file a brief in this case expressing the views of the United States. On May 27, 1999, the Solicitor General filed a Brief for the United States as Amicus Curiae. This brief responds to the Solicitor General's filing.

I. THE SOLICITOR GENERAL'S DETERMINATION THAT WISCONSIN'S POSITION REPRESENTS A REASONABLE INTERPRETATION OF THE UNDERLYING FEDERAL STATUTE UNDERSCORES THE IMPORTANCE OF THE QUESTION PRESENTED.

The Solicitor General phrased the question presented as "[w]hether Wisconsin's method of determining benefit eligibility and need levels for a class of Medicaid applicants is consistent with the requirement of 42 U.S.C. 1396a(a)(17)(D) that such methods not 'take into account the financial responsibility' for the applicant of any other person except a parent or spouse" (Solicitor General Br. at I). To the extent that the Solicitor General has attempted to answer that question, his position appears to be that Wisconsin's method is consistent with the statutory requirement. The Solicitor General writes: "[t]hat the decision below rests on a permissible interpretation of Section 1396a(a)(17)(D) does not require the contrary conclusion concerning the different interpretation of that provision advanced by petitioner" (*id.* at 16).[1]

Neither respondents nor the Solicitor General disputes that this case presents an important question. Respondents merely state that they would prefer the case be remanded to the district court to work out implementation of the Seventh

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[1] *See also id.* at 8 ("The court of appeals in this case adopted one plausible interpretation of the relevant provisions of the Medicaid Act. While the alternative construction advanced by petitioner is not unreasonable . . . ."); *id.* at 16 (noting "existence of reasonable textual and policy arguments on both sides of the issue") and; *id.* at 14 ("The court of appeals adopted one permissible answer to that question, holding that the use of such a standard does violate Section 1396a(a)(17)(D)").

Circuit's decision before any review by this Court.[2] The Solicitor General notes that the Medicaid provision at issue in this case is an "important exception" to former AFDC standards (Solicitor General Br. at 9), discusses at some length how the Secretary of Health and Human Services (hereafter "Secretary") has struggled with the very issue presented in this case (*see id.* at 10-14, 16-18), and concludes with the point that "[t]he existence of reasonable textual and policy arguments on both sides of the issue has consistently led the Secretary to acknowledge that the question presented in this case is a difficult one, to which there may be a number of plausible answers" (*id.* at 16-17).

The Solicitor General's position against the granting of a writ of certiorari is based on the fact that there is no conflict with this Court's precedent, there is no split in the circuits and that the Secretary withdrew the proposed regulations that would have been in conflict with the Seventh Circuit's decision (*id.* at 9, 18-19). Petitioners never made any claim to the contrary, and in their Petition for a Writ of Certiorari argued only that this case raises an important federal question.

The Solicitor General provides a rather detailed discussion of the Secretary's proposed regulations on this issue which would have required all States to use a methodology like Wisconsin's, the subsequent comments on the proposed regulations, and the withdrawal of the proposed regulations to "allow States participating in the Medicaid program the greatest possible flexibility to apply those provisions in light of their own state plans, administrative structures, resource constraints, and policy priorities" (Solicitor General Br. at 18, citing 59 Fed. Reg. at 43,052). The Solicitor General specifically notes that the "method for determining eligibility proposed by the Secretary in *Sneede*

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[2] *See* Respondents' Br. in Opposition, No. 98-1041, at 5 (filed Jan. 1999) ("at its current stage of development – this case does not present an important issue of federal law"); *see also id.* at 4, 7.

[v. Kizer, No. C89-1932, 1990 WL 155532 (N.D. Cal. June 8, 1990), *aff'd mem.*, 951 F.2d 360 (9th Cir. 1991), *cert. denied*, 506 U.S. 939 (1992)], was thus essentially the same as the Wisconsin method at issue in this case" (Solicitor General Br. at 12). (The Seventh Circuit relied heavily upon the decision in *Sneede* in deciding the case now before this Court (*see* Pet.-Ap. A-12 to A-13).) The Solicitor General states that if the Secretary had issued the regulations she had proposed which used the statutory construction as Wisconsin uses it, that construction "would have been not only permissible, but authoritative" (Solicitor General Br. at 17), and adds a footnote that the Ninth Circuit in *Sneede* was wrong to suggest "that the terms of the Medicaid Act compelled the result it reached, regardless of the Secretary's construction of the Act" (Solicitor General Br. at 17 n.7).

The Solicitor General agrees with Wisconsin that the Seventh Circuit's decision creates an inconsistency between the determinations of income and need since in calculating the income of a given child part of the mother's income is attributed to that child, and to her spouse and other children, yet the consideration of other children is excluded from the determination of the number of people to include when determining the appropriate level of need of that child (*see* Solicitor General Br. at 16).[3]

The Solicitor General also agrees with Wisconsin that "[i]t is realistic to assume that a parent's resources will be stretched evenly over herself, her spouse, and all of her dependents," but the Solicitor General errs when he states that "'economies of scale'" may not make sense in a program concerning medical assistance, because unlike other costs, a mother does not have to buy less medical care for a second child because she has already bought it for a first child

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[3] The practical effect of the Seventh Circuit's decision is to raise the income eligibility level for Medicaid in Wisconsin for any family with more than one child.

(Solicitor General Br. at 15 n.5). This statement shows a basic misunderstanding of the Medicaid program—assuming there are economies of scale in determining the income eligibility threshold of an applicant, means only that Wisconsin is assuming a family of six has a lower need level per person than a family of two. Under Medicaid if an individual is eligible he is entitled to free medical care (with exceptions not relevant here).

The answer to the question presented will have an enormous impact on the entire system of Medicaid eligibility calculation, not only in Wisconsin, but in all states. While respondents and the Solicitor General limit their discussion to Medicaid applicants who have their own income and who have failed to be covered under both Wisconsin's determination as to eligibility as a group and eligibility as an individual (the proposed class), the rationale underlying the Seventh Circuit's decision, that considering non-financially responsible family members (*i.e.*, a child applicant's siblings or an adult applicant's children) as part of a household when determining the appropriate level of need violates the "anti-deeming" provisions, underlies all of Wisconsin's determinations of Medicaid eligibility, because each determination includes an income threshold assessment for a family.[4]

In sum, Wisconsin's interpretation of 42 U.S.C. § 1396a(a)(17) is reasonable. The Secretary proposed rules

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[4] The court of appeals' opinion is also internally inconsistent on this point. It would permit the parent or parents of a child applicant to be considered as part of that child's household in determining the child's level of need (*i.e.*, the need level would be one-half of the need level for a family of two if one parent, and one-third the need level of a family of three if two parents). However, under the court of appeals' definition, this would be considering the income and resources of non-financially responsible people since the child is not responsible for his parent(s). This means the court of appeals' logic would require each child applicant's need to be that of a family of one.

which would have made Wisconsin's method of calculating Medicaid eligibility mandatory for all States. The Secretary's current position is to give the States flexibility to comply with 42 U.S.C. § 1396a(a)(17). The Solicitor General expressly stated that Wisconsin's legal position is a reasonable interpretation of the relevant statutory provisions. Yet, because of the decision of the court of appeals in this case, the State of Wisconsin and the other two states in the Seventh Circuit (as well as the States in the Ninth Circuit under *Sneede*) will be prevented from using a reasonable, sensible, and, in petitioners' view, lawful, method of calculating Medicaid eligibility.

II. THIS CASE IS RIPE FOR REVIEW BY THIS COURT.

Both respondents and the Solicitor General agree with the State of Wisconsin that this case presents a pure question of law and there is no dispute of fact. While respondents argue that further district court proceedings should be had to force Wisconsin to develop a new methodology for determining Medicaid eligibility to comply with the Seventh Circuit's decision, there is no need to have such proceedings take place prior to a decision by this Court on the underlying question of law.

The Solicitor General includes a footnote in his brief which states, without citation, that the impact of the Seventh Circuit's decision is "obscured by Wisconsin's impending implementation (in July 1999) of a 'child health plan' approved under the State Children's Health Insurance Program, 42 U.S.C. 1397aa *et seq.*" (Solicitor General Br. at 18 n.8). This footnote is a reference to Wisconsin's receiving federal approval to implement "BadgerCare" which expands Wisconsin's Medicaid coverage to a higher income eligibility threshold. BadgerCare is a Title 19 (Medicaid) expansion using Title 21 (Children's Health Insurance Program or CHIP) funds. This means that the same Medicaid income eligibility

rules at issue in this case must be applied to BadgerCare. Accordingly, contrary to the Solicitor General's implication, the impact of the Seventh Circuit's decision is only more important following the implementation of BadgerCare. All BadgerCare does is shift the eligibility determination to a different income level and therefore add more people for whom Wisconsin must make that income threshold eligibility determination.

CONCLUSION

The petition for writ of certiorari should be granted.

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